

Health, Welfare
Public Service

300
-57

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION
Marvin L. Bills

FILED SEP 24 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

31909

STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4116

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Kansas</u> b. COUNTY <u>Johnson</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kansas City</u>		c. CITY OR TOWN <u>Fairway</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St Lukes Hosp.</u>		d. STREET ADDRESS <u>5306 Pawnee Lane</u> (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
Length of stay in lb <u>30 min.</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>William Henry Helmers</u>			4. DATE OF DEATH Month Day Year <u>Sept. 2, 1957</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 28, 1897</u>
9. AGE (In years last birthday) <u>60</u>		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Vice President</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FURNITURE Helmers Mfg. Co.</u>	11. BIRTHPLACE (City and state or country) <u>Louisburg Kansas</u>
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>			
13a. FATHER'S NAME <u>Oscar Helmers</u>		13b. MOTHER'S MAIDEN NAME <u>Grace Aults</u>	14. NAME OF HUSBAND OR WIFE <u>Bessie Ackers Helmers</u>
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>486-07-2763</u>	17. INFORMANT Address <u>Fairway Kas.</u> <u>Bessie Ackers Helmers 5306 Pawnee Lane</u>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Ventricular Fibrillation</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Atherosclerosis, Heart failure - very rapid</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) _____			INTERVAL BETWEEN ONSET AND DEATH <u>45⁰⁰</u>
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.			
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
20f. CITY, TOWN, OR LOCATION		COUNTY STATE	
21. I attended the deceased from <u>6-25-57</u> to <u>9-2-57</u> and last saw her/him alive on <u>8-22-57</u> Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>Marvin L. Bills, M.D.</u> (Degree or title)		22b. ADDRESS <u>411 Nichols Rd KC</u>	
22c. DATE SIGNED <u>9-5-57</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE <u>9/4/57</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Mt Muncie</u>		23d. LOCATION (City, town, or county) (State) <u>Leavenworth Kansas</u>	
24. FUNERAL DIRECTOR <u>Stine & McClure</u>		ADDRESS <u>K. C. Mo.</u>	
25. DATE RECD: BY LOCAL REG. <u>9-3-57</u>		26. REGISTRAR'S SIGNATURE <u>Neva Marshall</u>	

(Licensed Embalmer's Statement on Reverse Side)

Dec. 1-1930
will be in office 8:30 a.m.

DEC 8 1961

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by Student Embalmer No. working under my personal supervision.

Student
Signature of Student Embalmer

Signed *Eugene L. Lemmon*

Licensed Embalmer No. *463*

P. O. Address *.....*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.