

Health, Welfare, Public Service

FILED SEP 19 1957

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

31931  
STATE FILE NUMBER  
3985

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 3985

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-57

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kansas City</u>		c. CITY OR TOWN <u>Kansas City</u>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>General Hospital No. 1</u>		d. STREET ADDRESS (If outside, give location) <u>1419 E. 8th</u>	
3. NAME OF DECEASED (Type or print) First: <u>Bert</u> Middle: <u>S.</u> Last: <u>Houck</u>		4. DATE OF DEATH Month: <u>8</u> Day: <u>18</u> Year: <u>1957</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-28-81</u>
9. AGE (In years last birthday) <u>76</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Pensioner</u>	11. BIRTHPLACE (City and state or country) <u>Iowa</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Pensioner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>State</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13a. FATHER'S NAME <u>Unknown</u>		13b. MOTHER'S MAIDEN NAME <u>Unknown</u>	
13c. NAME OF HUSBAND OR WIFE <u>Unknown</u>		14. NAME OF HUSBAND OR WIFE <u>Unknown</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>none</u>	
17. INFORMANT <u>Gen. Hosp Records</u>		Address <u>15. C. Mo.</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>Chronic myelogenous leukemia</u>			INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			<u>1041</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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 _____ 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>8-15-57</u> to <u>8-18-57</u> and last saw <u>him</u> alive on <u>8-18-57</u> Death occurred at <u>11:55 AM</u> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>B. I. Burns, M.D.</u> (Degree or title)		22b. ADDRESS <u>General Hospital No. 1</u>	
22c. DATE SIGNED <u>8-19-57</u>			
23a. BURIAL, CREMATION, OR OTHER (Specify)	23b. DATE <u>8-29-57</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Weston Dental</u>	23d. LOCATION (City, town, or county) (State) <u>15. C. Mo</u>
24. FUNERAL DIRECTOR <u>Blain E. Weisert</u>		25. DATE RECD. BY LOCAL REG. <u>8-26-57</u>	26. REGISTRAR'S SIGNATURE <u>Norm Winchall</u>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

B. I. BURNS

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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 *Blaine E. Williams* .....

Licensed Embalmer No. *4075* .....

P. O. Address *N.C. 876* .....

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.