

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-005978

STATE FILE NUMBER

542

FILED FEB 24 1958

Registration District No. 149

Primary Registration District No. 1002

Registrar No.

1. PLACE OF DEATH a. COUNTY <b>JACKSON</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY <b>Jackson</b>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>KANSAS CITY</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>KANSAS CITY</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>V A HOSPITAL</b>		Length of stay in lb <b>40 years</b>	d. STREET ADDRESS (If outside, give location) <b>315 WEST 38TH</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <b>SANDFORD NORBERT ZWART</b>			4. DATE OF DEATH Month Day Year <b>January 30, 1958</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 9, 1899</b>		9. AGE (In years last birthday) <b>58</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Hardware</b>	11. BIRTHPLACE (City and state or country) <b>Kansas City, Missouri</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13a. FATHER'S NAME <b>Hernard Henry Zwart</b>		13b. MOTHER'S MAIDEN NAME <b>Catherine Rodgers</b>		14. NAME OF HUSBAND OR WIFE <b>none</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>568 07 5247</b>		17. INFORMANT Address <b>VA Hospital Official Records, K. C. Mo.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute bronchopneumonia of left lower lobe</b>					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) <b>Bronchogenic carcinoma of the right lung, PRIMARY</b>					
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? <b>YES</b> <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 <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. Attended the deceased from <b>November 13, 1957</b> to <b>January 30, 1958</b> Death occurred at <b>10:55</b> a.m. on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <b>ROBERT FLINNER, M.D.</b>			22b. ADDRESS <b>VA Hospital, Kansas City, Mo.</b>		22c. DATE SIGNED <b>1-30-58</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>2-1-58</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mt. St. Mary's</b>		23d. LOCATION (City, town, or county) (State) <b>Kansas City, Mo.</b>
24. FUNERAL DIRECTOR ADDRESS <b>Freeman Mortuary Kansas City, Mo.</b>			25. DATE RECD. BY LOCAL REG. <b>2-1-58</b>	26. REGISTRAR'S SIGNATURE <b>neva minshall</b>	

(Licensed Embelmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard non-removable ink when certifying. All diseases in Part I must be causally related.

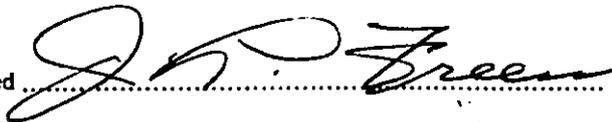
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Health, Welfare and Public Service

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  .....

Licensed Embalmer No. 12939  
P. O. Address H. O. W.

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.