

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-025433

STATE FILE NUMBER

FILED AUG 8 1958

Registration District No.

149

Primary Registration District No.

1002

Registrar's No.

3500

S. 300 D
1-57

All diseases in Part I must be causally related. No symptoms will be listed.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY JACKSON		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MISSOURI b. COUNTY JACKSON	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN KANSAS CITY		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN KANSAS CITY Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION VA HOSPITAL		Length of stay in hospital 85 DAYS	d. STREET ADDRESS (If outside, give location) 1015 CHERRY Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last CLYDE O. CURTIS			4. DATE OF DEATH Month Day Year JULY 17 1958
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> 3 DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 3-2-81
9a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) Paperhanger-retired		9b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 77
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	10. FUNDING YEAR Months Days Hours Min.
11. BIRTHPLACE (City and state or country) STELLA, NEBRASKA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME JOHN W. CURTIS		13b. MOTHER'S MAIDEN NAME SUSAN, NEAL	14. NAME OF HUSBAND OR WIFE
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or unknown) Yes		16. SOCIAL SECURITY NO. 428170925419 506-12-1997	17. INFORMANT Address VA HOSPITAL OFFICIAL RECORDS
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia, right and left lower lobes Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) Vesicular pulmonary emphysema			INTERVAL BETWEEN ONSET AND DEATH 5271
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 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 WORKING <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 4-23-58 to 7-17-58 Death occurred at 1:30 A.M. on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE J. A. TURNER, M.D. <i>J. A. Turner M.D.</i>		22b. ADDRESS VA Hospital, Kansas City, Mo.	22c. DATE SIGNED 7-17-58
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL	23b. DATE July 18, 1958	23c. NAME OF CEMETERY OR CREMATORY NATIONAL CEMETERY	23d. LOCATION (City, town, or county) (State) FORT LEAVENWORTH KANSAS
24. FUNERAL DIRECTOR D.U. NEWCOMER'S SONS, KANSAS CITY, MO.		25. DATE RECD. BY LOCAL REG. 7-18-58	26. REGISTRAR'S SIGNATURE <i>New Marshall</i>



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 *Harold E. Cheternal*

Licensed Embalmer No. 3035

P. O. Address *Ed. Cal.*

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.