

Health,
& Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-036426
STATE FILE NUMBER

FILED OCT 23 1958

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4705

300
1-57

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 lb. 188 days	d. STREET ADDRESS (If outside, give location) 5916 Charlotte Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last LON EARL RAYMOND HOLLCROFT			4. DATE OF DEATH Month Day Year OCTOBER 5, 1958		
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5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-26-90	9. AGE (In years last birthday) 68	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PAINTER	10b. KIND OF BUSINESS OR INDUSTRY Retired	11. BIRTHPLACE (City and state or country) ALTON, Indiana	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME N. S. Hollcroft	13b. MOTHER'S MAIDEN NAME Sarah A. Gailey	14. NAME OF HUSBAND OR WIFE MYRTLE M. HOLLCROFT
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give dates of service) YES WW I	16. SOCIAL SECURITY NO. 515-09-3138	17. INFORMANT Official Records VA Hospital, K.C., Mo. Address
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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>Cerebral softening</u>		INTERVAL BETWEEN ONSET AND DEATH 452.8
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Resected aneurysm of right common carotid</u>	
	DUE TO (c) <u>Arteriosclerosis</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? 1 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.)
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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
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21. I attended the deceased from <u>April 1, 1958</u> to <u>October 5, 1958</u> and I sign for him alive on <u>10-5-58</u> Death occurred at <u>5:53 P.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>E. Foroughi M.D.</u>	22b. ADDRESS VA Hospital, K.C., Mo.	22c. DATE SIGNED 10-6-58
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE 10-7-58	23c. NAME OF CEMETERY OR CREMATORY Blue Springs Cemetery	23d. LOCATION (City, town, or county) (State) Blue Springs, Mo.
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24. FUNERAL DIRECTOR Geo. C. Carson & Sons, Indep., Mo.	ADDRESS	25. DATE RECD. BY LOCAL REG. 10-6-58	26. REGISTRAR'S SIGNATURE <u>Irene Marshall</u>
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All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION



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 *Raymond A. Stoen*
Licensed Embalmer No. *4266*

P. O. Address *Independence, Mo.*

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.