Health, & Welfare Public Service

300
1-57

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

58-044011
STATE FILE NUMBER

FILED DEC 18 1958 Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 5659

1. PLACE OF DEATH
a. COUNTY Jackson
b. CITY OR TOWN (If outside corporate limits, give TOWNSHIP only) Kansas City — Inside Limits Yes ☒ No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) Trinity Lutheran — Length of stay in 1b 6 Wks

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Mo b. COUNTY Clay
c. CITY OR TOWN No KC. 16 6001 — Inside Limits Yes ☐ No ☐
d. STREET ADDRESS (If outside, give location) Rt 13 — Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print) First Thomas Middle Last Burns

4. DATE OF DEATH Month Nov. Day 30 Year 1958

5. SEX Male
6. COLOR OR RACE White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH Dec 27-1896
9. AGE (In years last birthday) 61 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mill Wright
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (City and state or country) Lone Jack Mo
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME Robert Burns
13b. MOTHER'S MAIDEN NAME Lila Phelps
14. NAME OF HUSBAND OR WIFE Nellie Burns

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) No
16. SOCIAL SECURITY NO. 493-12-6132
17. INFORMANT Mrs. Nellie Burns Address of the Home

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinoma Pancreas — INTERVAL BETWEEN ONSET AND DEATH 6 weeks
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b)
DUE TO (c) 157X
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Diabetes Mellitus
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒ 2

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
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. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
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 10-11-58, to 11-30-58 and last saw her/him alive on 11-30-58
Death occurred at 3:55 PM m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) James E McCormick M.D.
22b. ADDRESS 4030 N Oak KC 16 Mo
22c. DATE SIGNED 12-1-58

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE 12-2-58
23c. NAME OF CEMETERY OR CREMATORY Pleasant Hill Cem
23d. LOCATION (City, town, or county) (State) Pleasant Hill Mo

24. FUNERAL DIRECTOR D.W. Newcomers Sons ADDRESS N.K.C.
25. DATE RECD. BY LOCAL REG. 12-1-58
26. REGISTRAR'S SIGNATURE Neva Minshall

(Licensed Embalmer's Statement on Reverse Side)

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

James E. Mc Cormick

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 Glenn H. Dell

Licensed Embalmer No. 4586

P. O. Address K.C. 16 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.