Health, Welfare ublic ervice

300 -57

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

58-047135

STATE FILE NUMBER

FILED JAN 19 1959

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 6253

1. PLACE OF DEATH
a. COUNTY Jackson
b. CITY OR TOWN (If outside corporate limits, give TOWNSHIP only) Kansas City, Mo. Inside Limits Yes [x] No [ ]
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) VA Hospital Length of stay in 1b 7 days

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY Ray
c. CITY OR TOWN Lexington C990 Inside Limits Yes [x] No [ ]
d. STREET ADDRESS (If outside, give location) 906½ Main Reside on Farm Yes [ ] No [x]

3. NAME OF DECEASED (Type or print) First JOHN Middle B. Last HELM SR.

4. DATE OF DEATH Month Day Year 12-30-58

5. SEX Male
6. COLOR OR RACE White
7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [x]
8. DATE OF BIRTH 2-28-98
9. AGE (In years last birthday) 60 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) Custodian
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (City and state or country) Lexington, Mo
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13a. FATHER'S NAME Van Buren Helm
13b. MOTHER'S MAIDEN NAME Emma Burris
14. NAME OF HUSBAND OR WIFE

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW2
16. SOCIAL SECURITY NO. 487-05-0743
17. INFORMANT Address VA Hospital Official Records, K. C. Mo.

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) Hepatic coma
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Cirrhosis of liver
DUE TO (c) 5810
INTERVAL BETWEEN ONSET AND DEATH

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 [ ] NO [x] 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. VA attended the deceased from December 23, 1958 to December 30, 1958 and last saw him on
Death occurred at 8:05 P m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Joseph C. Meek Jr MD
22b. ADDRESS VA Hospital, K. C. Mo.
22c. DATE SIGNED 12-30-58

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE 1-2-59
23c. NAME OF CEMETERY OR CREMATORY Mashpelah Cemetery
23d. LOCATION (City, town, or county) (State) Lexington, Mo

24. FUNERAL DIRECTOR ADDRESS Harold P. Walker Lexington, Mo
25. DATE RECD. BY LOCAL REG. 1-1-59
26. REGISTRAR'S SIGNATURE Neva Minshall

(Licensed Embalmer's Statement on Reverse Side)

All diseases in Part I must be causally related.

Joseph C. Meek, Jr USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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 L. Walker

Licensed Embalmer No. 4588

P. O. Address Lexington, Ind

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.