Health, Welfare Public Service

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FILED FEB 27 1959

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-005508
STATE FILE NUMBER 783

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

1. PLACE OF DEATH
a. COUNTY Jackson
b. CITY OR TOWN Kansas City — Inside Limits Yes [X] No [ ]
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) St Marys Hosp. — Length of stay in Hospital 2 Days

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Mo. b. COUNTY Jackson
c. CITY OR TOWN Oak Grove — Inside Limits Yes [ ] No [X]
d. STREET ADDRESS (If outside, give location) 3 Miles S.W. — Reside on Farm Yes [X] No [ ]

3. NAME OF DECEASED (Type or print) First: Peter Middle: Nelson Last: Dickhout

4. DATE OF DEATH Month Day Year: Feb. 9 1959

5. SEX Male

6. COLOR OR RACE White

7. MARRIED [X] **NEVER MARRIED** [ ] **WIDOWED** [ ] **DIVORCED** [ ]

8. DATE OF BIRTH Oct, 4 1896

9. AGE (In years last birthday) 62 — 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) Dock Foreman

10b. KIND OF BUSINESS OR INDUSTRY Rail Road

11. BIRTHPLACE (City and state or country) Greenwood Mo.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME Peter S. Dickhout

13b. MOTHER'S MAIDEN NAME Emily E. Richie

14. NAME OF HUSBAND OR WIFE Mildred Dickhout

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No. (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 702-14-5627

17. INFORMANT Address: Mildred Dickhout Oak Grove Mo.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) bronchogenic carcinoma of lung with mediastinal metastasis — INTERVAL BETWEEN ONSET AND DEATH: unknown
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b)
DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): bronchopneumonia

19. WAS AUTOPSY PERFORMED? YES [X] NO [ ]

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 February 8, 1959 to February 9th 59 and last saw him alive on February 9, 1959
Death occurred at 7:25 p.m. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) J. E. Castles M.D.

22b. ADDRESS 1002 Argyle Bldg., K.C.6, Mo.

22c. DATE SIGNED 2/11/59

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial

23b. DATE 2/13/1959

23c. NAME OF CEMETERY OR CREMATORY Lee's Summit

23d. LOCATION (City, town, or county) (State) Lee's Summit Mo.

24. FUNERAL DIRECTOR Langsford Funeral Home
ADDRESS Lee's Summit Mo.

25. DATE RECD. BY LOCAL REG. 2-11-59

26. REGISTRAR'S SIGNATURE Neva Minshall

(Licensed Embalmer's Statement on Reverse Side)

MEDICAL CERTIFICATION

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

J. E. Castles

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. .....

P. O. Address .....

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.