Health, Welfare Public Service

300
1-57

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-005786
STATE FILE NUMBER

FEB 17 1959 Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 524

1. PLACE OF DEATH
a. COUNTY Jackson
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City — Inside Limits Yes ☐ No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) Curtis Nursing Home 7505 E. 87th — Length of stay in 1b 10 yrs

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Mo b. COUNTY Jackson
c. CITY OR TOWN Kansas City — Inside Limits Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location) 7505 E. 87th — Reside on Farm Yes ☐ No ☒

3. NAME OF DECEASED (Type or print) First Middle Last: Victor E. Ott

4. DATE OF DEATH Month Day Year: 1-22-59

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒
8. DATE OF BIRTH: 12-6-1903
9. AGE (In years last birthday): 55 — 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): Disabled Vet.
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (City and state or country): Jefferson City Mo
12. CITIZEN OF WHAT COUNTRY? U.S.

13a. FATHER'S NAME: Joseph W. Ott
13b. MOTHER'S MAIDEN NAME: Ida Burnett
14. NAME OF HUSBAND OR WIFE: Divorced

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): Yes World War II
16. SOCIAL SECURITY NO.: 499-14-7098
17. INFORMANT Address: Mrs Esther Walton (Lister) Columbia 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) Bronchial Pneumonia (Bronchopneumonia) — INTERVAL BETWEEN ONSET AND DEATH: few days
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)

19. WAS AUTOPSY PERFORMED? YES ☐ 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 3-26-1956, to 1-22-59 and last saw him alive on 1-21-59
Death occurred at 8:30 A.M. m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): J. A. Nigro - M.D.
22b. ADDRESS: 1222 McGee
22c. DATE SIGNED: 1-27-59

23a. BURIAL, CREMATION, REMOVAL (Specify): removal
23b. DATE: 1-29-59
23c. NAME OF CEMETERY OR CREMATORY: Nat'l Cemetary Fort Leavenworth Kans
23d. LOCATION (City, town, or county) (State)

24. FUNERAL DIRECTOR ADDRESS: Peter B. Lozelina K.C. Mo
25. DATE RECD. BY LOCAL REG.: 1-27-59
26. REGISTRAR'S SIGNATURE: Neva Minshall

(Licensed Embalmer's Statement on Reverse Side)

MEDICAL CERTIFICATION

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

J. A. Nigro

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 Bette B Kizetina

Licensed Embalmer No. 4273

P. O. Address KC 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.