

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-009404

STATE FILE NUMBER 1544

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

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"/>	3. 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 V.A. Hospital		Length of stay in lb 40 yrs	d. STREET ADDRESS (If outside, give location) 7219 Lydia Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) JOHN C. GEIGER			4. DATE OF DEATH Month Day Year 3rd 24th 1959		
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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 7-7-89	9. AGE (In years last birthday) 69 yrs	10. UNDER 1 YEAR Months Days	11. UNDER 24 HRS Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during working life, even if retired) ORDINANCE Auto Mechanic	10b. KIND OF BUSINESS OR INDUSTRY FT. LEAVENWORTH, KS Transportation	11. BIRTHPLACE (City and state or country) Sandoval, Illinois	12. CITIZEN OF WHAT COUNTRY? U.S. A.
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13a. FATHER'S NAME JOHN B. GEIGER	13b. MOTHER'S MAIDEN NAME CAROLINE MERTON	14. NAME OF HUSBAND OR WIFE Mable Geiger
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes VWT	16. SOCIAL SECURITY NO. 493-22-3134	17. INFORMANT Address V.A. Hospital, Kansas City, Mo
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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) Massive cerebral hemorrhage		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) _____	
	DUE TO (c) Arteriosclerosis; cerebral vessels. 331 1/2	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Arterial hypertension		19. WAS AUTOPSY PERFORMED? YES <input 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 a.m. p.m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK <input checked="" 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 Kansas City	COUNTY Missouri	STATE
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21. Attended the deceased from **March 18, 1959** to **March 24, 1959** and last saw him/her on **March 24, 1959**
Death occurred at **3:30 A.** m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <i>J. A. Turner</i> (Degree or title)	22b. ADDRESS MD V.A. Hospital, Kansas City, Mo	22c. DATE SIGNED 3-24-59
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23a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION	23b. DATE MAR. 26, 1959	23c. NAME OF CEMETERY OR CREMATORY D.W. Newcomer's Sons	23d. LOCATION (City, town, or county) (State) Kansas City Missouri
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24. FUNERAL DIRECTOR D.W. Newcomer's Sons, Kansas City	ADDRESS Missouri	25. DATE RECD. BY LOCAL REG. 3-25-59	26. REGISTRAR'S SIGNATURE <i>new minshall</i>
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

J. A. Turner

All diseases in Part I must be causally related.



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 *Chester X Brown*

Licensed Embalmer No. *493*

P. O. Address *K E V*

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.