

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-013423

STATE FILE NUMBER

1790

FILED APR 27 1959

Registration District No.

149

Primary Registration District No.

1002

Registrar's No.

300
-57

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"/>	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 1236 W. 61st Terr		Length of stay in lb 65 yrs	d. STREET ADDRESS (If outside, give location) 1236 W. 61st Terr. Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First JOSEPH Middle G. Last McKENZIE			4. DATE OF DEATH Month April Day 6 Year 1959		
---	--	--	--	--	--

5. SEX D Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 7, 1876	9. AGE (In years last birthday) 82	10. FUNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	12. IF UNDER 24 HRS Hours	13. IF UNDER 24 HRS Min.
--------------------------------	----------------------------------	---	--	--	-----------------------------	-----------------------------	------------------------------	-----------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired	10b. KIND OF BUSINESS OR INDUSTRY Interstate Bakers	11. BIRTHPLACE (City and state or country) Allen Co. Indiana	12. CITIZEN OF WHAT COUNTRY? U. S. A.
---	---	--	---

13a. FATHER'S NAME Unknown	13b. MOTHER'S MAIDEN NAME Unknown	14. NAME OF HUSBAND OR WIFE Louise McKenzie
--------------------------------------	---	---

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. 495-03-5410	17. INFORMANT Earl H. Schrader, Sr.	Address 1236 W. 61st Terr
--	---	---	-------------------------------------

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cerebral vascular accident instant		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)	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) carcinoma of prostate		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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.)
---	--

20c. TIME OF INJURY Hour p.m. Month, Day, Year	20d. INJURY OCCURRED WHILE AT <input 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	20g. COUNTY Missouri	20h. STATE
--	---	--	--	--------------------------------	------------

21. I attended the deceased from 1951 to 4/6/59 and last saw her/him alive on 4/6/59 Death occurred at 1:00 P. m on the date stated above; and to the best of my knowledge, from the causes stated.
--

21a. SIGNATURE James R. McVay (Degree or title) MD.	21b. ADDRESS 814 V.F.W. Bldg.	21c. DATE SIGNED 4/7/59
--	---	-----------------------------------

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE Apr. 8, 1959	22c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery	22d. LOCATION (City, town, or county) (State) Kansas City Missouri
--	----------------------------------	---	--

24. FUNERAL DIRECTOR D.W. Newcomer's Sons, K.C. Missouri	25. DATE RECD. BY LOCAL REG. 4-8-59	26. REGISTRAR'S SIGNATURE Leva Marshall
--	---	---

James R. Mc Vay USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE MEDICAL CERTIFICATION

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 *Edward M. Stover*

Licensed Embalmer No. *445*
P. O. Address *K.C. 110*

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.