

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-017897

FILED JUN 9 1959

Registration District No. 149 Primary Registration District No. 1002

STATE FILE NUMBER 2367  
Registrar's No.

1. PLACE OF DEATH a. COUNTY <b>JACKSON</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY <b>Jackson</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>KANSAS CITY</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>KANSAS CITY</b> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>V A HOSPITAL</b>		Length of stay in lb <b>8 years</b>	d. STREET ADDRESS (If outside, give location) <b>4234 WABASH</b> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>GEORGE</b> Middle <b>D</b> Last <b>PARTRIDGE</b>			4. DATE OF DEATH Month <b>May</b> Day <b>11</b> , Year <b>1959</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>February 4, 1907</b>
9. AGE (In years last birthday) <b>52</b>		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Cook</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>Lacygne, Kansas</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13a. FATHER'S NAME <b>Charlie Partridge</b>	
13b. MOTHER'S MAIDEN NAME <b>Nelly Oliver</b>		14. NAME OF HUSBAND OR WIFE <b>-</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes WWII</b>		16. SOCIAL SECURITY NO. <b>573 18 3289</b>	17. INFORMANT <b>VA Hospital Official Records, K. C. Mo.</b> Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Occlusion right pulmonary artery by blood clot</b> DUE TO (b) <b>Occlusion left popliteal artery &amp; vien by blood clots</b> DUE TO (c) <b>Generalized arteriosclerosis</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Recent occlusion left anterior descending coronary artery by blood clot</b>			INTERVAL BETWEEN ONSET AND DEATH <b>4201</b>
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 Month, Day, Year a.m. p.m.		20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORKING 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 COUNTY STATE	
21. Attended the deceased from <b>March 12, 1959</b> to <b>May 11, 1959</b> Death occurred at <b>11:10</b> a m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <b>A. J. WILLIAMS, M.D.</b> (Degree or title)		22b. ADDRESS <b>VA Hospital, Kansas City, Mo.</b>	22c. DATE SIGNED <b>5-11-59</b>
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <b>MAY 14, 1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>NATIONAL CEM</b>	23d. LOCATION (City, town, or county) (State) <b>Fort Scott Kansas City, MO. Kans.</b>
24. FUNERAL DIRECTOR <b>D W McCombs Sons MO.</b>		25. DATE RECD. BY LOCAL REG. <b>5-12-59</b>	26. REGISTRAR'S SIGNATURE <b>neva Minshall</b>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 *Bern Lawler* .....

Licensed Embalmer No. *4915*  
P. O. Address *K.C. 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.