

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-017980

FILED JUN 9 1959

Registration District No. 149 Primary Registration District No. 1002

STATE FILE NUMBER 2412
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 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 VA HOSPITAL		Length of stay in lb 66 Years		d. STREET ADDRESS (If outside, give location) 7000 E. 40 Hiway		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last CARL SPICER TAYS			4. DATE OF DEATH Month Day Year MAY 11, 1959				
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> 3 DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 3-26-93	9. AGE (In years last birthday) 66		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED RESTAURANT OWNER		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) ST. JOSEPH, MO.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME HENRY C. TAYS			13b. MOTHER'S MAIDEN NAME OLIVE SWAIN			14. NAME OF HUSBAND OR WIFE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give year or dates of service) YES WW I		16. SOCIAL SECURITY NO. 486-26 2605		17. INFORMANT Address Official Records VA Hospital, K.C., 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) PNEUMONIA						INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) Anaplastic, oat cell carcinoma, right lower lobe bronchus		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 <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <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 WORK <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		COUNTY STATE	
21. I attended the deceased from November 16, 1958 to May 11, 1959 and certify the time of death occurred at 2:30 P.M. on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE Arne Heidegaard, M.D. ARNE HEIDEGAARD, M. D.				22b. ADDRESS VA Hospital, K.C., Mo.		22c. DATE SIGNED 5-11-59	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 5-13-1959	23c. NAME OF CEMETERY OR CREMATORY Floral Hills		23d. LOCATION (City, town, or county) (State) Kansas City, Missouri		
24. FUNERAL DIRECTOR Floral Hills Memorial Chapel			ADDRESS K.C. MO.		25. DATE RECD. BY LOCAL REG. 5-14-59	26. REGISTRAR'S SIGNATURE Neva Marshall	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

70

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 *Forest D. Boldenow*

Licensed Embalmer No. *4714*
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.

K
A