

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-021735

FILED JUN 24 1959 Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 2765

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <b>JACKSON</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>KANSAS</b> b. COUNTY <b>Meant</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>PAOLA</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 1b. <b>73 days</b>	d. STREET ADDRESS (If outside, give location) <b>105 EAST KASKASKIA</b> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

-3. NAME OF DECEASED (Type or print) First <b>RALPH</b> Middle Last <b>TOMLINSON</b>			4. DATE OF DEATH Month <b>June</b> Day <b>4</b> Year <b>1959</b>		
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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 type="checkbox"/>	8. DATE OF BIRTH <b>August 25, 1892</b>	9. AGE (In years last birthday) <b>66</b>	10. UNDER 1 YEAR Months Days Hours Min.	11. UNDER 24 HRS
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Meat Cutter</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>	11. BIRTHPLACE (City and state or country) <b>Jewell County, Kansas</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
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13a. FATHER'S NAME <b>Charles Tomlinson</b>	13b. MOTHER'S MAIDEN NAME <b>Anna Grisdell</b>	14. NAME OF HUSBAND OR WIFE <b>Jessie TOMLINSON</b>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give dates of service) <b>Yes WWI</b>	16. SOCIAL SECURITY NO. <b>UNKNOWN</b>	17. INFORMANT Address <b>VA Hospital Official Records, K. C. Mo</b>
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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) <b>Bronchopneumonia</b>		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>Paraplegia</b>	
	DUE TO (c) <b>Metastatic carcinoma of larynx</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>161X</b>		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.)
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20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.
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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 COUNTY STATE
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21. Attended the deceased from <b>March 12, 1959</b> to <b>June 4, 1959</b> Death occurred at <b>6:40</b> a m on the date stated above; and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE (Degree or title) <b>T. G. ORR, M.D. JR.</b>	22b. ADDRESS <b>VA Hospital, Kansas City, Mo.</b>	22c. DATE SIGNED <b>6-4-59</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>	23b. DATE <b>JUNE 4, 1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>PAOLA CEM</b>	23d. LOCATION (City, town, or county) (State) <b>PAOLA, KANSAS</b>
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24. FUNERAL DIRECTOR ADDRESS <b>N W Newcome's Son, MO.</b>	25. DATE RECD. BY LOCAL REG. <b>6-5-59</b>	26. REGISTRAR'S SIGNATURE <b>neva minshall</b>
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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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 *C. J. Nelson* ..... Licensed Embalmer No. *4421* ..... P. O. Address *Kansas City*

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.