

DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-024995

FILED VS AUG 1 0 1959

STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 3612

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| 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) KANSAS CITY | | Length of stay in 1b 15 years | | 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, K.C., MO. | | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | d. STREET ADDRESS (If outside, give location) 3843 Park | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Morris Middle Phillip Last Blansett | | | 4. DATE OF DEATH Month July Day 26 Year 1959 | | | | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH 9/6/13 | 9. AGE (last birthday) 45 | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HR | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Store Clerk | | 10b. KIND OF BUSINESS OR INDUSTRY Higbee, Mo. | | 11. BIRTHPLACE (City and state or country) U.S.A. | | 12. CITIZEN OF WHAT COUNTRY U.S.A. | | |
| 13a. FATHER'S NAME J. B. Blansett | | | 13b. MOTHER'S MAIDEN NAME Gertrude Phillips | | 14. NAME OF HUSBAND OR WIFE Millie Blansett | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes 1-28-42 to 6-20-42 | | | 16. SOCIAL SECURITY NO. 498 18 2538 | 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) Increased Intercranial Pressure DUE TO (b) Brain Tumor (Glioblastoma) DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | | | | | | INTERVAL BETWEEN ONSET AND DEATH | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) | | | | | PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown | | | |
| 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 _____ a.m. _____ p.m. | Month, Day, Year | | | | | | | |
| 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. X attended the deceased from 7/21/59 to 7/26/59 Death occurred at 11:30 p.m. on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | | | |
| 22a. SIGNATURE <i>Edmays MD.</i> (Degree or title) | | | 22b. ADDRESS VA Hospital, K. C., Mo. | | 22c. DATE SIGNED 7-26-59 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Removal | 23b. DATE July 27, 1959 | 23c. NAME OF CEMETERY OR CREMATORY LOG CHABEL CEM | | 23d. LOCATION (City, town, or county) HIGBEE, MO. | | | | |
| 24. FUNERAL DIRECTOR D.W. New Comer, Son, MO ADDRESS R. 2 | | 25. DATE RECD. BY LOCAL REG. 7-27-59 | 26. REGISTRAR'S SIGNATURE <i>Neva Minchall</i> | | | | | |

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____ or by _____, Student Embalmer No. _____ working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Raymond T. Fuller

Licensed Embalmer No. 4818

P. O. Address K.C., Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to do so 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.