

59-025002

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

FILED VS JUL 27 1959

Registration District No. 149

Primary Registration District No. 002

STATE FILE NUMBER

Registrar's No. 3358

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>La Fayette</b>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kansas City</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Lexington</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>VA Hospital</b>		Length of stay in lb. <b>20 days</b>	d. STREET ADDRESS (If outside, give location) <b>102 S. 18th</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Victor M.</b> Middle <b>Bour</b> Last			4. DATE OF DEATH Month <b>7th</b> Day <b>8th</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>4-12-88</b>	9. AGE (In years at birthday) <b>71 yrs</b>	IF UNDER 24 HRS Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Grocery Clerk</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Groceries</b>	11. BIRTHPLACE (City and state or country) <b>Lexington, Mo</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>
13a. FATHER'S NAME <b>Victor Bour</b>		13b. MOTHER'S MAIDEN NAME <b>Anna Martin</b>		14. NAME OF HUSBAND OR WIFE <b>Unknown</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> <b>3-5-18 to 11-7-18</b>		16. SOCIAL SECURITY NO. <b>unk.</b>		17. INFORMANT Address <b>VA Hospital Records, Kansas City, Mo</b>	
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>Intestinal obstruction, terminal ileum</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>Incarcerated right inguinal hernia</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) <b>Adenocarcinoma of cecum with ulceration</b>					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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 <input type="checkbox"/> NOT WHILE WORKING <input checked="" type="checkbox"/> 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 <b>June 18, 1959</b> to <b>July 8, 1959</b> and the death occurred at <b>7:10 a.m.</b> on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <b>Albert L. Chasson</b> (Degree or title) <b>ALBERT L. CHASSON, M.D.</b>			22b. ADDRESS <b>VA Hospital, Kansas City, Mo</b>		22c. DATE SIGNED <b>7-8-59</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>7-8-59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Lexington</b>		23d. LOCATION (City, town, or county) (State) <b>Lexington, Missouri</b>
24. FUNERAL DIRECTOR ADDRESS <b>Stine &amp; McClure, Kansas City, Mo.</b>			25. DATE RECD. BY LOCAL REG. <b>7-9-59</b>	26. REGISTRAR'S SIGNATURE <b>Neva Marshall</b>	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

OCT 14 1959

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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 *William M. [Signature]* .....  
Licensed Embalmer No. *4648* .....  
P. O. Address *Kansas City, 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.