

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-025181

FILED VS AUG 14 1959

3666

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. 1002 Registrar's No. _____

1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)			
a. COUNTY JACKSON		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN KANSAS CITY		a. STATE MISSOURI		b. COUNTY Green	
Length of stay in lb 26 days		c. CITY OR TOWN ASH GROVE		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION V A HOSPITAL		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS BOX 255		(If outside, give location) Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)				4. DATE OF DEATH			
First ARTHUR		Middle HENDERSON		Last HENDERSON		Month July Day 28 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 11-23-71	9. AGE (last birthday) 87	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) Olathe, Kansas		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME James Henderson		13b. MOTHER'S MAIDEN NAME Matilda Landis		14. NAME OF HUSBAND OR WIFE Ida B. Henderson			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes		16. SOCIAL SECURITY NO. NONE		17. INFORMANT VA Hospital Official Records, K. C. Mo. Address _____			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:							INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) Congestive heart failure							
DUE TO (b) Arteriosclerotic heart disease							
DUE TO (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Duodenal ulcer with hemorrhage					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 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 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. <input checked="" type="checkbox"/> attended the deceased from July 2, 1959 to July 28, 1959 Death occurred at 9:30 p on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) ALBERT L. CHASSON, M.D.				22b. ADDRESS VA Hospital, Kansas City, Mo.		22c. DATE SIGNED 7-29-59	
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL	23b. DATE JULY 29, 1959	23c. NAME OF CEMETERY OR CREMATORY NATIONAL CEM		23d. LOCATION (City, town, or county) KANSAS CITY, MO.		(State) _____	
24. FUNERAL DIRECTOR D. W. NEWCOMER'S SONS		ADDRESS K.C. Mo.		25. DATE RECD. BY LOCAL REG. 7-29-59	26. REGISTRAR'S SIGNATURE Neva Marshall		

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 Chester Brown

Licensed Embalmer No. 4931

P. O. Address 1504

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