

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-025440

FILED JUL 17 1959

Registration District No. 149 Primary Registration District No. 1002 STATE FILE NUMBER Registrar's No. 3296

| | | | | | |
|---|-------------------------------|---|--|---|---|
| 1. PLACE OF DEATH a. COUNTY <u>Jackson</u> | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u> | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kansas City</u> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | c. CITY OR TOWN <u>Kansas City</u> | | Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>VA Hospital</u> | | Length of stay in lb. <u>off 73 yrs</u> | d. STREET ADDRESS (If outside, give location) <u>3118 Agnes</u> | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| -3: NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>R.</u> Last <u>Snead</u> | | | 4. DATE OF DEATH Month <u>7th</u> Day <u>4th</u> Year <u>1959</u> | | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>Negro</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER-MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>2-13-86</u> | 9. AGE <u>73 yrs</u> If UNDER 1 YEAR: Months _____ Days _____ If UNDER 24 HRS: Hours _____ Min. _____ | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Trash Hauler</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Sanitary</u> | 11. BIRTHPLACE (City and state or country) <u>Pleasant Hill, Mo</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> |
| 13a. FATHER'S NAME <u>Ves Snead</u> | | 13b. MOTHER'S MAIDEN NAME <u>Almira Rucher</u> | | 14. NAME OF HUSBAND OR WIFE <u>Jessie Snead</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes 7-19-18 to 8-15-19</u> | | 16. SOCIAL SECURITY NO. <u>493228478</u> | 17. INFORMANT <u>VA Hospital Records, K.C., Mo.</u> Address _____ | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary congestion & edema</u> | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Decompensated cardiac disease</u> | | | | | |
| DUE TO (c) <u>Arteriosclerosis, coronary arteries</u> | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Emphysema, pulmonary; and bronchial carcinoma</u> | | | | | 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 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. <input checked="" type="checkbox"/> attended the deceased from <u>June 5, 1959</u> to <u>July 4, 1959</u> and caused the death. Death occurred at <u>1:20 p</u> m on the date stated above; and to the best of my knowledge, from the causes stated. | | | | | |
| 22a. SIGNATURE <u>J. A. Turner</u> (Degree or title) <u>MD</u> | | | 22b. ADDRESS <u>VA Hospital, Kansas City, Mo</u> | | 22c. DATE SIGNED <u>7-4-59</u> |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>removal</u> | | 23b. DATE <u>7-8-1959</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Westlawn Cemetery</u> | | 23d. LOCATION (City, town, or county) (State) <u>Kansas City, Kansas</u> |
| 24. FUNERAL DIRECTOR <u>Mrs. Meek's Mortuary, K. C. Mo.</u> | | 25. DATE RECD. BY LOCAL REG. <u>7-6-59</u> | 26. REGISTRAR'S SIGNATURE <u>Steve Marshall</u> | | |

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

ALL ENTRIES IN PART I MUST BE EXACTLY RELATED.

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 *Millard B. Parker*

Licensed Embalmer No. *5013*

P. O. Address *N.C.W.*

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.