

DI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-025474

FILED VS AUG 14 1959

Registration District No. 449 Primary Registration District No. 1002 Registrar's No. 3660 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Kansas b. COUNTY Johnson	
b. CITY (If outside corporate limits, give TOWNSHIP only) Kansas City		Length of stay in 1b 5 days	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, KC MO		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 2926 N. Allis Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First LOUIS Middle WALTER Last TILLMAN			4. DATE OF DEATH Month July Day 25th Year 1959	
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5. SEX Male	6. COLOR OR RACE Negro	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 11/17/97	9. AGE (last birthday) 61	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cleaner	10b. KIND OF BUSINESS OR INDUSTRY ---	11. BIRTHPLACE (City and state or country) Guthrie, Oklahoma	12. CITIZEN OF WHAT COUNTRY U.S.A.
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13a. FATHER'S NAME Hulah Tillman	13b. MOTHER'S MAIDEN NAME Elizabeth Burton	14. NAME OF HUSBAND OR WIFE Olivia Tillman
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WWII	16. SOCIAL SECURITY NO. unknown	17. INFORMANT Address VA HOSPITAL RECORDS, K. C. MO.
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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) Pulmonary carcinomatosis, primary site unknown		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) _____	
	DUE TO (c) _____	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (e)	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
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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.)
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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 _____
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21. **VA** attended the deceased from **7/20/59** to **7/25/59** and has been notified by _____
Death occurred at **3850 p.** m 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, K. C. Mo.	22c. DATE SIGNED 7/26/59
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23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE 7/28/59	23c. NAME OF CEMETERY OR CREMATORY Ft Leavenworth	23d. LOCATION (City, town, or county) (State) Leavenworth. Lv. Kansas
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24. FUNERAL DIRECTOR Bailey Funeral Home, K.C. Kansas	25. DATE RECD. BY LOCAL REG. 7-28-59	26. REGISTRAR'S SIGNATURE Walter Marshall
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DOCUMENT

BY AFFIDAVIT OF Albert L. Chasson MEDICAL CERTIFICATION

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 *Chambers*

Licensed Embalmer No. 4437

P. O. Address *W. G. M.*

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.