

DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-029335

FILED VS SEP 1 1959

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 3940

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 Allen	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City		Length of stay in 1b 6 days	c. CITY OR TOWN Humboldt Inside Limits Yes <input type="checkbox"/> No <input checked="" 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) RR# 2 Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First WALTER Middle W. Last STORY			4. DATE OF DEATH Month August Day 11th Year 1959		
5. SEX Male	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 5/17/96	9. AGE (last birthday) 63	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Toronto, Kansas	12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME Wallace Story		13b. MOTHER'S MAIDEN NAME Ollie M. Coburn		14. NAME OF HUSBAND OR WIFE NONE	
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. 515-30-6325	17. INFORMANT Address VA HOSPITAL RECORDS, K. C. MO.		

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) Myocardial infarct?		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Aneurism of sinus of valsalva with rupture into right atrium	
DUE TO (c)		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Obstructive jaundice, etiology unknown		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. Attended the deceased from 8-5-59 to 8-11-59
Death occurred at 10:25 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, K. C. MO.	22c. DATE SIGNED 8-12-59
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL	23b. DATE AUG 12, 1959	23c. NAME OF CEMETERY OR CREMATORY CHANUTE CEM	23d. LOCATION (City, town, or county) CHANUTE, KANSAS
24. FUNERAL DIRECTOR ADDRESS D. W. NEWCOMER'S SONS K. C. MO.		25. DATE RECD. BY LOCAL REG. 8-13-59	26. REGISTRAR'S SIGNATURE <i>Neva Minchell</i>

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 M. Hardy

Licensed Embalmer No. 4913

P. O. Address Indpls, Ind

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