DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

FILED VS SEP 1 1959

59-029377
STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 6002 Registrar's No. 3994

1. PLACE OF DEATH
a. COUNTY: JACKSON
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: KANSAS CITY
Length of stay in 1b: 59 days
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: VA Hospital KCMO
Inside Limits: Yes [X] No [ ]

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MISSOURI b. COUNTY: Jackson
c. CITY OR TOWN: INDEPENDENCE
Inside Limits: Yes [ ] No [X]
d. STREET ADDRESS (If outside, give location): 19311 EAST TRUMAN ROAD
Reside on Farm: Yes [X] No [ ]

3. NAME OF DECEASED (Type or print): First: RALPH Middle: MAURICE Last: WILEY
4. DATE OF DEATH: Month August Day 14 Year 1959
5. SEX: Male
6. COLOR OR RACE: White
7. Married [X] Never Married [ ] Widowed [ ] Divorced [ ]
8. DATE OF BIRTH: 3-20-97
9. AGE (last birthday): 62
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): Painter
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (City and state or country): Independence, Missouri
12. CITIZEN OF WHAT COUNTRY: U.S.A.
13a. FATHER'S NAME: Samuel B. Wiley
13b. MOTHER'S MAIDEN NAME: Bessie Mackay
14. NAME OF HUSBAND OR WIFE: Sylvia Wiley
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): Yes WWI and WWII
16. SOCIAL SECURITY NO.: 490 09 2815
17. INFORMANT: VA Hospital Official Records, K. C. Mo. Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac arrythmia
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Right atrium infarct, recent
DUE TO (c) Artertioscerotic heart disease
INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)
PART III. If deceased was female was there a pregnancy in last 90 days. [ ] Yes [ ] No [ ] Unknown
19. WAS AUTOPSY PERFORMED? YES [X] NO [ ]
20a. ACCIDENT [ ] SUICIDE [ ] HOMICIDE [ ]
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 [ ] NOT WHILE AT WORK [ ]
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
20f. CITY, TOWN, OR LOCATION COUNTY STATE
VA
21. I attended the deceased from June 16, 1959 to August 14, 1959
Death occurred at 12:05 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, MD. Albert L. Chasson
22b. ADDRESS: VA Hospital, Kansas City, Missouri
22c. DATE SIGNED: 8-14-59
23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: Aug. 17, 1959
23c. NAME OF CEMETERY OR CREMATORY: Woodlawn
23d. LOCATION (City, town, or county) (State): Independence, Mo.
24. FUNERAL DIRECTOR: OTT & MITCHELL ADDRESS: INDEP, MO.
25. DATE RECD. BY LOCAL REG.: 8-17-59
26. REGISTRAR'S SIGNATURE: Neva Minshall

(Licensed Embalmer's Statement on Reverse Side)

BY AFFIDAVIT OF DOCUMENT

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____ Signed Henry G. Milc

Signature of Student Embalmer

Licensed Embalmer No. 392

P. O. Address Indep. M

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