

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-032459

FILED VS SEP 23 1959 / 47

4330

STATE FILE NUMBER

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

1. PLACE OF DEATH a. COUNTY JACKSON		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY LINN	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN KANSAS CITY		Length of stay in 1b 138 days	c. CITY OR TOWN WINIGAN Inside Limits 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 (If outside, give location) General Delivery Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First HENRY Middle EVERETT Last MC CONNELL			4. DATE OF DEATH Month SEPTEMBER Day 4 Year 1959			
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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 12-5-93	9. AGE (last birthday) 65	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) Farmer	10b. KIND OF BUSINESS OR INDUSTRY Agriculture	11. BIRTHPLACE (City and state or country) Winigan, Missouri	12. CITIZEN OF WHAT COUNTRY U.S.A.
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13a. FATHER'S NAME James McConnell	13b. MOTHER'S MAIDEN NAME Alice Brown	14. NAME OF HUSBAND OR WIFE Olive McConnell
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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 9-3-18 to 1-25-19	16. SOCIAL SECURITY NO. UNKNOWN	17. INFORMANT Official Records, VA Hospital, K.C.MO. Address _____
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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) Carcinoma of the lungs		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 (a)		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 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.)
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20c. TIME OF INJURY Hour _____ Month, Day, Year _____ a.m. _____ p.m. _____

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.) VA	20f. CITY, TOWN, OR LOCATION VA	COUNTY _____ STATE _____
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21. I attended the deceased from **April 19, 1959** to **September 4, 1959** beginning with **7:00** p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <i>Robert L. Klaus</i>	(Degree or title) MD	22b. ADDRESS VA Hospital, Kansas City, Mo.	22c. DATE SIGNED 9-4-59
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23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL	23b. DATE SEPT 5 1959	23c. NAME OF CEMETERY OR CREMATORY GREEN CITY CEM	23d. LOCATION (City, town, or county) (State) GREEN CITY, MO.
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24. FUNERAL DIRECTOR D. W. NEWCOMER'S SONS K. C. MO.	25. DATE RECD. BY LOCAL REG. 9-7-59	26. REGISTRAR'S SIGNATURE <i>Neva Marshall</i>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF
Robert L. Klaus

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 Albert L. Savage

Licensed Embalmer No. 4812

P. O. Address Kansas City

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.