

**FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**59-032468**

**FILED VS SEP 23 1959**

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4363 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Jackson</b>					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kansas City</b>		Length of stay in lb <b>18 mos</b>		c. CITY OR TOWN <b>Hickman Mills</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>VA Hospital</b>			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>10408 Richmond</b>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>Jim T.</b> Middle <b>McWhorter</b> Last <b>McWhorter</b>				4. DATE OF DEATH Month <b>9th</b> Day <b>7th</b> Year <b>1959</b>					
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>3-1-94</b>	9. AGE (last birthday) <b>66 yrs</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Construction</b>		11. BIRTHPLACE (City and state or country) <b>Paducah, Texas</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.</b>		
13a. FATHER'S NAME <b>Calvin McWhorter</b>			13b. MOTHER'S MAIDEN NAME <b>Sara Lewis</b>			14. NAME OF HUSBAND OR WIFE <b>Lora M. McWhorter</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes 5-17-20 to 5-16-21</b>			16. SOCIAL SECURITY NO. <b>465 03 3735</b>		17. INFORMANT Address <b>V.A. Hospital Records, K.C., Mo.</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pnaumonia, Right Lower Lobe, with abscess cavity</b>							INTERVAL BETWEEN ONSET AND DEATH		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Chronic brain disease</b>									
DUE TO (c) <b>Arteriosclerosis, cerebral</b>									
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				
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 <b>VA</b> 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 <b>VA</b>		COUNTY		STATE	
21. I attended the deceased from <b>August 27, 1959</b> to <b>September 7, 1959</b> <sup>her</sup> <del>my</del> <del>husband's</del> <del>decease</del> Death occurred at <b>3:15p</b> m on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Degree or title) <b>Albert L. Chasson</b>				22b. ADDRESS <b>V.A. Hospital, K.C., Mo</b>				22c. DATE SIGNED <b>9-7-59</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>		23b. DATE <b>SEPT 8, 1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>SHAMROCK CEM</b>		23d. LOCATION (City, town, or county) <b>SHAMROCK, TEXAS</b>				
24. FUNERAL DIRECTOR ADDRESS <b>D. W. NEWCOMER'S SONS K. C. MO.</b>				25. DATE RECD. BY LOCAL REG. <b>9-8-59</b>		26. REGISTRAR'S SIGNATURE <b>Neva Marshall</b>			

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 Chester K Brown

Licensed Embalmer No. 493

P. O. Address K P 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.