RI DIVISION OF HEALTH — STANDARD CERTIFICATE OF DEATH

59-032530

FILED VS SEP 23 1959

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4319 STATE FILE NUMBER

DED

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 30 yrs
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION VA Hospital
Inside Limits Yes ☐ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY Jackson
c. CITY OR TOWN Kansas City
Inside Limits Yes ☐ No ☐
d. STREET ADDRESS (If outside, give location) 5716 Lydia
Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print) First: Archie Middle: G. Last: Prater
4. DATE OF DEATH Month: 9th Day: 3rd Year: 1959
5. SEX: Male
6. COLOR OR RACE: White
7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐
8. DATE OF BIRTH: 3-23-94
9. AGE (last birthday): 65 yrs
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): Clerk
10b. KIND OF BUSINESS OR INDUSTRY: Insurance
11. BIRTHPLACE (City and state or country): Meta, Mo.
12. CITIZEN OF WHAT COUNTRY: U.S.A.
13a. FATHER'S NAME: Henry Prater
13b. MOTHER'S MAIDEN NAME: Mary A. Williams
14. NAME OF HUSBAND OR WIFE: Mary Prater
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): yes (If yes, give war or dates of service): W. W. I
16. SOCIAL SECURITY NO.: 487-07-4450
17. INFORMANT: Mrs. Mary Cecil Prater Address: 5716 Lydia

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) Cerebral Hemorrhage, Right, Massive
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Chronic Granulocytic Leukemia
DUE TO (c)
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 ☒ 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.) VA
20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from June 10, 1959 to September 3, 1959 and last saw him alive on
Death occurred at 10:25 pm on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) ALBERT L. CHASSON, Albert L. Chasson MD
22b. ADDRESS VA Hospital, Kansas City, Mo
22c. DATE SIGNED 9-4-59

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE 9-5-1959
23c. NAME OF CEMETERY OR CREMATORY Floral Hills
23d. LOCATION (City, town, or county) (State) Kansas City Missouri

24. FUNERAL DIRECTOR Floral Hills Memorial Chapels, Inc ADDRESS K.C. MO
25. DATE RECD. BY LOCAL REG. 9-5-59
26. REGISTRAR'S SIGNATURE Neva Marshall

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

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 Forrest D Coldson

Licensed Embalmer No. 4714

P. O. Address KC Ma

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