

R DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-032629

FILED VS SEP 23 1959 149

4289

STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4289

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 1b <b>30 years</b>	c. CITY OR TOWN <b>Kansas City</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>General Hospital</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>4500 Nichols Parkway</b> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>Jr.</b> Last <b>Tyrone</b>			4. DATE OF DEATH Month <b>8</b> Day <b>31</b> Year <b>59</b>			
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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>2/20/1898</b>	9. AGE (last birthday) <b>61</b>	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) <b>Dept of Agriculture</b>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>Los Angeles Calif.</b>	12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>
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13a. FATHER'S NAME <b>Asron Tyrone</b>	13b. MOTHER'S MAIDEN NAME <b>Lillie Johnson</b>	14. NAME OF HUSBAND OR WIFE <b>Geraldine Tyrone</b>
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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) <b>No</b>	16. SOCIAL SECURITY NO. <b>493-26-0725</b>	17. INFORMANT <b>Mrs. Geraldine Tyrone</b> Address <b>4500 J/C. Nichols Parkway</b>
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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) <b>focal peritonitis and pancreatitis</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>acute &amp; chronic cholecystitis and cholelithiasis and choledocholithiasis</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

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.)
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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
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21. I attended the deceased from **8-25-59** to **8-31-59** and last saw <sup>xxx</sup>him alive on **8-31-59**  
Death occurred at **7:05 P.M.** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <b>Abraham Gelpin</b>	22b. ADDRESS <b>2400 Cherry</b>	22c. DATE SIGNED <b>9-1-59</b>
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23a. BURIAL, CREMATION, OR REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>9/2/1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Calvary Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Sedalia Missouri</b>
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24. FUNERAL DIRECTOR <b>D.W. Newcomers Sons</b> ADDRESS <b>1831 Brush Creek Blvd.</b>	25. DATE RECD. BY LOCAL REG. <b>9-2-59</b>	26. REGISTRAR'S SIGNATURE <b>Walter Marshall</b>
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Kansas City Missouri (Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

BY AFFIDAVIT OF Abraham Gelpin Medical Certification

VS JUN 21 1960

**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 Roger L. Fuller

Licensed Embalmer No. 4818

P. O. Address KC Mo

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.