RI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

59–032637

FILED VS SEP 25 1959

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4398 STATE FILE NUMBER

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH
a. COUNTY Jackson
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City — Length of stay in Tb: 4 months
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION VA Hospital, K. C. Mo. — Inside Limits: Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Kansas b. COUNTY ~~Johnson~~ Wyandotte
c. CITY OR TOWN Kansas City — Inside Limits: Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location) 37 So. Valley — Reside on Farm: Yes ☐ No ☒

3. NAME OF DECEASED (Type or print): First EARNEST Middle Last WALTERS JR.
4. DATE OF DEATH: Month 9th Day 5th Year 1959
5. SEX: Male
6. COLOR OR RACE: White
7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐
8. DATE OF BIRTH: 5/4/27
9. AGE (last birthday): 32
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): Supervisor Diaper Svc Co.
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (City and state or country): Centralia, Kansas
12. CITIZEN OF WHAT COUNTRY: U.S.A.
13a. FATHER'S NAME: Orville E. Walters
13b. MOTHER'S MAIDEN NAME: Iva Keeslar
14. NAME OF HUSBAND OR WIFE: Gloria J. Walters
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): WWII
16. SOCIAL SECURITY NO.: 513-20-1598
17. INFORMANT: V.A Hospital Records, K.C., Mo — Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pulmonary edema and congestion
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Congestive heart failure
DUE TO (c) Hodgkins 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 ☒ 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 August 17, 1959, to September, 5, 1959 ~~[illegible]~~ last saw him/her alive.
Death occurred at 3:30 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 Albert L. Chasson MD
22b. ADDRESS: V.A. Hospital, K.C., Mo
22c. DATE SIGNED: 9-5-59

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal
23b. DATE: 9-10-57
23c. NAME OF CEMETERY OR CREMATORY: Donna Sanger Cem.
23d. LOCATION (City, town, or county) (State): Donna Sanger Ks

24. FUNERAL DIRECTOR: Wallen Funeral Svc
ADDRESS: Sno Ks
25. DATE REC'D. BY LOCAL REG.: 9-9-59
26. REGISTRAR'S SIGNATURE: Neva Minshall

(Licensed Embalmer's Statement on Reverse Side)

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 Robert E Herron

Licensed Embalmer No.: 4849

P. O. Address K. C. Ks.

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