

THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

59-039882

FILED VS DEC 7 1959

Registration District No. 149 Primary Registration District No. 1002 STATE FILE NUMBER Registrar's No. 5615

V. S. 300
 Rev. 1-57

securing the medical certification in the specific manner required by 193.140 MoRS 1949.
 All diseases in Part I must be causally related.

Pat A. Barelli
 MEDICAL CERTIFICATION
 USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY JACKSON				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MO. b. COUNTY JACKSON					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN Kansas City		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St Joseph Hosp			Length of stay in 1b 50 YRS		d. STREET ADDRESS (If outside, give location) 2511 E 68th Terr.		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Newton Middle A. Last ALCORN				4. DATE OF DEATH Month 11 Day 20 Year 59					
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 3-25-89		9. AGE (In years last birthday) 70	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RET. Htg + SHEET METAL CONTRACTOR			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) SEDAIA Missouri		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13a. FATHER'S NAME JAMES ALCORN			13b. MOTHER'S MAIDEN NAME AMANDA Hill			14. NAME OF HUSBAND OR WIFE wife MAE E. ALCORN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 487 16-4475		17. INFORMANT Address KC Mo. Mrs MAE ALCORN 2511 E 68th Terr					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHO PNEUMONIA, bilateral INTERVAL BETWEEN ONSET AND DEATH 3 DAYS									
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Metastatic Carcinoma of lungs, spleen, liver, etc 4 Months									
DUE TO (c) Primary CANCER of LARYNX 3 YRS									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 161X							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.)						
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	
21. I attended the deceased from 1956 , to 11-20-59 and last saw her/him alive on 11-20-59 Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE Pat A Barelli (Degree or title) M.D.				22b. ADDRESS 425 E 63rd Kansas City Mo.				22c. DATE SIGNED 20 Nov 59	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City, town, or county) (State)		
Burial		11-21-1959		FLORAHILLS CEMETERY			K. P. MO.		
24. FUNERAL DIRECTOR Floral Hill Memorial Chapels Inc			ADDRESS KC Mo.		25. DATE RECD. BY LOCAL REG. 11-21-59		26. REGISTRAR'S SIGNATURE Neva Minshel		

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by, Student Embalmer No. working under my personal supervision.

Student
Signature of Student Embalmer

Signed *Ernest Robinson*

Licensed Embalmer No. *471K*
P. O. Address *15 P. M. S.*

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