

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

**59-040123**

**FILED VS. NOV 17 1959**

149

Registration District No. \_\_\_\_\_ Primary Registration District No. 1002 Registrar's No. \_\_\_\_\_

**5217**

STATE FILE NUMBER

UNRECORDED

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> 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>40 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>V A HOSPITAL</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>3814 EAST 37TH</b>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First <b>ROBERT</b> Middle _____ Last <b>HORRID</b>				4. DATE OF DEATH Month <b>October</b> Day <b>28</b> Year <b>1959</b>									
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Negro</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>1-20-10</b>		9. AGE (last birthday) <b>49</b>		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) <b>Truck Driver</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>WE Murray Transfer Co.</b>		11. BIRTHPLACE (City and state or country) <b>Marianna, Arkansas</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>					
13a. FATHER'S NAME <b>Solomon Horrid</b>				13b. MOTHER'S MAIDEN NAME <b>Mary Willy</b>				14. NAME OF HUSBAND OR WIFE <b>Clarice Horrid</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes WWII</b>				16. SOCIAL SECURITY NO. <b>499 09 9855</b>		17. INFORMANT Address <b>VA Hospital Official 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:										INTERVAL BETWEEN ONSET AND DEATH			
IMMEDIATE CAUSE (a) <b>Bronchopneumonia, bilateral with abscess RLL</b>													
DUE TO (b) <b>Cerebral cortical atrophy</b>													
DUE TO (c) <b>Cardiac arrest during cystoscopy with pentathol anesthesia</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 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 _____ 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					
<b>VA</b>													
21. <input checked="" type="checkbox"/> attended the deceased from <b>July 1, 1959</b> to <b>October 28, 1959</b> Death occurred at <b>10:40 pm</b> 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, M.D.</b> <i>Albert L. Chason</i>				22b. ADDRESS <b>VA Hospital, Kansas City, Mo.</b>				22c. DATE SIGNED <b>10-29-59</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>11-3-59</b>		23c. NAME OF CEMETERY OR CREMATORY <b>National</b>		23d. LOCATION (City, town, or county) (State) <b>Ft. Leavenworth, Kans.</b>							
24. FUNERAL DIRECTOR <b>Watkins Bros. Funeral Home 18th &amp; Benton</b>				25. DATE RECD. BY LOCAL REG. <b>10-30-59</b>		26. REGISTRAR'S SIGNATURE <i>Neva Mitchell</i>							

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

MS-DEC 17 1959

**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

*Bruce R. Watkins*

Licensed Embalmer No. 4500

P. O. Address 18th + Feut

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.