

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-001445

FILED VS FEB 1 1960

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 327 STATE FILE NUMBER

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>13 days</b>	c. CITY OR TOWN <b>RAYTOWN</b> Inside Limits Yes <input checked="" 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>9515 EAST 64TH</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>RAY</b> Middle <b>RHOADES</b> Last <b>CASSELL</b>			4. DATE OF DEATH Month <b>January</b> Day <b>18</b> Year <b>1960</b>		
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>10-3-92</b>	9. AGE (last birthday) <b>67</b>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Civil Service</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>Raytown, Missouri</b>	12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13a. FATHER'S NAME <b>George Theodore Cassell</b>		13b. MOTHER'S MAIDEN NAME <b>Bessie Young</b>		14. NAME OF HUSBAND OR WIFE <b>Marie Cassell</b>	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, no, or unknown) (If yes, give war or dates of service) <b>Yes WWI</b>	16. SOCIAL SECURITY NO. <b>494-40-6109</b>	17. INFORMANT <b>Mrs. Marie Cassell, 9515 E. 64, Raytown, Mo</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:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <b>Bronchopneumonia, R&amp;L.L.</b>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>Uremia</b>	
DUE TO (c) <b>Chronic pyelonephritis, bilateral</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 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.)
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 **January 5, 1960** to **January 18, 1960**  
Death occurred at **9:12 P** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <b>J. A. Turner</b> <b>J. A. TURNER, MD</b> (Degree or title)	22b. ADDRESS <b>VA Hospital, Kansas City, Mo.</b>	22c. DATE SIGNED <b>1-18-60</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>1-20-1960</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Floral Hills</b>	23d. LOCATION (City, town, or county) (State) <b>Kansas City, Mo.</b>
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24. FUNERAL DIRECTOR <b>Floral Hills Memorial Chapel</b>	ADDRESS <b>KCMO.</b>	25. DATE RECD. BY LOCAL REG. <b>1-20-60</b>	26. REGISTRAR'S SIGNATURE <b>Neve Trinal</b>
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DOCUMENT

MEDICAL CERTIFICATION

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. Coldman

Licensed Embalmer No. 4714

P. O. Address PCUW.

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.