

DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-001936

FILED VS JAN 25 1960/49

Registration District No. \_\_\_\_\_ Primary Registration District No. 1002 Registrar's No. 319 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>JACKSON</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>Jackson</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>KANSAS CITY</u>		Length of stay in 1b <u>12 years</u>		c. CITY OR TOWN <u>KANSAS CITY</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>V A HOSPITAL</u>				Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>4241 CHESTNUT</u>	
3. NAME OF DECEASED (Type or print) First <u>LAWSON</u> Middle _____ Last <u>SYKES</u>				4. DATE OF DEATH Month <u>January</u> Day <u>11</u> Year <u>1960</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>8-26-16</u>	9. AGE (last birthday) <u>43</u>	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) <u>Laborer</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>Aberdeen, Mississippi</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
13a. FATHER'S NAME <u>Logan Sykes</u>			13b. MOTHER'S MAIDEN NAME <u>Josephine</u>			14. NAME OF HUSBAND OR WIFE <u>Lillie Sykes</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes</u> <u>WWI</u>			16. SOCIAL SECURITY NO. <u>510 26 3753</u>		17. INFORMANT <u>4241 Address Chestnut Mrs. Lillie Sykes, Kansas City, Missouri</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Peritoneal and mesentary carcinomatosis</u> DUE TO (b) <u>Adenocarcinoma of stomach, diffuse infiltrating type</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.							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. <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.) <u>VA</u>		20f. CITY, TOWN, OR LOCATION		COUNTY	STATE
21. I attended the deceased from <u>January 4, 1960</u> to <u>January 11, 1960</u> and last saw him alive on _____ Death occurred at <u>2:30</u> p.m. on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>ALBERT L. CHASSON, MD.</u> <i>Albert L. Chasson</i>				22b. ADDRESS <u>VA Hospital, Kansas City, Mo.</u>			22c. DATE SIGNED <u>1-12-60</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE <u>1/15/60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Westlawn Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Kansas City, Kansas</u>		
24. FUNERAL DIRECTOR <u>Mrs. Meek's Mortuary</u>			ADDRESS <u>K. C. Mo</u>	25. DATE RECD. BY LOCAL REG. <u>1-13-60</u>	26. REGISTRAR'S SIGNATURE <i>Neva Marshall</i>		

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

*Millard B. Park*

Licensed Embalmer No. 5813

P. O. Address A.C.

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.