

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

**-60-001944**

**FILED VS FEB 15 1960**

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 640 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>CLAY</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>KANSAS CITY</b>		Length of stay in 1b <b>2 Years</b>	c. CITY OR TOWN <b>NORTH KANSAS CITY</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>VA HOSPITAL, K.C., MO.</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>100 East 29th St.</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>JOYCE</b> Middle <b>ELAINE</b> Last <b>THOMPSON</b>			4. DATE OF DEATH Month <b>FEBRUARY</b> Day <b>2</b> Year <b>1960</b>		
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>9-23-13</b>	9. AGE (last birthday) <b>46</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>NURSE</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>HARPER, KANSAS</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>

13a. FATHER'S NAME <b>WILLIAM G. THOMPSON</b>		13b. MOTHER'S MAIDEN NAME <b>ANNA UNKNOWN</b>		14. NAME OF HUSBAND OR WIFE <b>N/A</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>YES WW II</b>		16. SOCIAL SECURITY NO. <b>500-34-0921</b>		17. INFORMANT Address <b>Wilma Coffman Sis 100 E 29th NKC, Mo.</b>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia, right lung</b>		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____		
DUE TO (c) <b>Carcinoma of ovary</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	
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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.)
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____
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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 _____
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21. I attended the deceased from **VA August 21, 1959** to **Feb 2, 1960** and last saw him **alive on**  
Death occurred at **5:45 P.M.** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <b>J. A. Turner, M.D.</b>	22b. ADDRESS <b>VA Hospital, Kansas City, Mo.</b>	22c. DATE SIGNED <b>2-3-60</b>
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23a. BURIAL (CREMATION, REMOVAL) (Specify) <b>REMOVAL</b>	23b. DATE <b>FEB 3, 1960</b>	23c. NAME OF CEMETERY OR CREMATORY <b>HAZELWOOD CEM</b>	23d. LOCATION (City, town, or county) (State) <b>SPRINGFIELD MO.</b>
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24. FUNERAL DIRECTOR ADDRESS <b>D. W. NEWCOMER'S SONS K.C. MO.</b>	25. DATE RECD. BY LOCAL REG. <b>2-3-60</b>	26. REGISTRAR'S SIGNATURE <b>Neva Minshall</b>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

APR 15 1960

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 Basil J. Home

Licensed Embalmer No. 4734  
P. O. Address N.C., m

\*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.