

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

**-60-006398**

**FILED VS MAR 7 1960**

149

Registration District No. \_\_\_\_\_ Primary Registration District No. 1002 Registrar's No. **1058**

STATE FILE NUMBER

INDEXED

|  |  |   |   |
|--|--|---|---|
| 1. PLACE OF DEATH  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) |   |
| a. COUNTY<br><b>JACKSON</b>  | a. STATE <b>MISSOURI</b> b. COUNTY <b>Jackson</b>                                    |   |   |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR<br>TOWN<br><b>KANSAS CITY</b>        | Length of stay in 1b<br><b>57 years</b>  | c. CITY OR TOWN<br><b>KANSAS CITY</b>   | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION<br><b>VA Hospital</b> | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS<br>(If outside, give location)<br><b>4533 HOLLEY</b>                | Reside on Farm<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |

|                                     |                         |                    |                     |                  |                          |                   |                     |
|-------------------------------------|-------------------------|--------------------|---------------------|------------------|--------------------------|-------------------|---------------------|
| 3. NAME OF DECEASED (Type or print) | First<br><b>FRANCIS</b> | Middle<br><b>J</b> | Last<br><b>IACY</b> | 4. DATE OF DEATH | Month<br><b>February</b> | Day<br><b>19,</b> | Year<br><b>1960</b> |
|-------------------------------------|-------------------------|--------------------|---------------------|------------------|--------------------------|-------------------|---------------------|

|                       |                                  |   |                                   |                                     |                                   |                                 |
|-----------------------|----------------------------------|---|-----------------------------------|-------------------------------------|-----------------------------------|---------------------------------|
| 5. SEX<br><b>Male</b> | 6. COLOR OR RACE<br><b>White</b> | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>5-4-00</b> | 9. AGE (last birthday)<br><b>59</b> | IF UNDER 1 YEAR<br>Months<br>Days | IF UNDER 24 HR<br>Hours<br>Min. |
|-----------------------|----------------------------------|---|-----------------------------------|-------------------------------------|-----------------------------------|---------------------------------|

|   |  |   |  |
|---|--|---|--|
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Freight agent</b> | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Railroad</b> | 11. BIRTHPLACE (City and state or country)<br><b>Kansas City, Mo.</b> | 12. CITIZEN OF WHAT COUNTRY<br><b>U.S.A.</b> |
|---|--|---|--|

|  |  |  |
|--|--|--|
| 13a. FATHER'S NAME<br><b>Thomas Iacy</b> | 13b. MOTHER'S MAIDEN NAME<br><b>Anne Griffin</b> | 14. NAME OF HUSBAND OR WIFE<br><b>Anne K. Iacy</b> |
|--|--|--|

|   |   |  |
|---|---|--|
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>Yes WWII</b> | 16. SOCIAL SECURITY NO.<br><b>708 18 7552</b> | 17. INFORMANT<br><b>VA Hospital Records, K.C. Mo<br/>Anne K. Iacy, 4533 Holley, K. C. Mo</b> |
|---|---|--|

|   |   |  |
|---|---|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:                          |   | INTERVAL BETWEEN ONSET AND DEATH   |
| IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b>   |   |  |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.  | DUE TO (b) <b>Chronic passive congestion and edema of lungs</b> |  |
|   | DUE TO (c) <b>Rheumatic heart disease with mitral stenosis</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.<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |

|   |   |  |
|---|---|--|
| 19. WAS AUTOPSY PERFORMED?<br>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<br>a.m.<br>p.m.  | Month, Day, Year   |

|   |  |                              |        |       |
|---|--|------------------------------|--------|-------|
| 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" 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 **February 16, 1960** to **February 19, 1960** and last saw him **drive off**.  
Death occurred at **3:30 p.m.** on the date stated above, and to the best of my knowledge, from the causes stated.

|  |                   |  |                                    |
|--|-------------------|--|------------------------------------|
| 22a. SIGNATURE<br><i>Albert L. Chabson</i> | (Degree or title) | 22b. ADDRESS<br><b>VA Hospital, Kansas City, Mo.</b> | 22c. DATE SIGNED<br><b>2-20-60</b> |
|--|-------------------|--|------------------------------------|

|  |                             |   |  |         |
|--|-----------------------------|---|--|---------|
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b> | 23b. DATE<br><b>2-22-60</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Calvary Cemetery</b> | 23d. LOCATION (City, town, or county)<br><b>Kansas City, Mo.</b> | (State) |
|--|-----------------------------|---|--|---------|

|  |                                   |  |   |
|--|-----------------------------------|--|---|
| 24. FUNERAL DIRECTOR<br><b>Melody-McGilley-Eylar</b> | ADDRESS<br><b>1800 E. Linwood</b> | 25. DATE RECD. BY LOCAL REG.<br><b>2-22-60</b> | 26. REGISTRAR'S SIGNATURE<br><i>Neva Minshall</i> |
|--|-----------------------------------|--|---|

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

Albert L. Chabson

STATEMENT BY LICENSED EMBALMER

400  
12 1960

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by  
or by Ray F Dickman, Student Embalmer No. 60  
working under my personal supervision.

Student Ray F Dickman Signed James E Backler  
Signature of Student Embalmer

Licensed Embalmer No. 4573

P. O. Address K. 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.