URI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

60-010905

FILED VS APR 4 1960

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 1680 STATE FILE NUMBER

NDED

1. PLACE OF DEATH
a. COUNTY JACKSON
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN KANSAS CITY — Length of stay in 1b: 67 Year
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION VA HOSPITAL — Inside Limits: Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MISSOURI b. COUNTY JACKSON
c. CITY OR TOWN KANSAS CITY — Inside Limits: Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location) 514 East 9th St. — Reside on Farm: Yes ☐ No ☒

3. NAME OF DECEASED (Type or print): First ROBERT Middle STANLEY Last DOVER

4. DATE OF DEATH: Month MARCH Day 21 Year 1960

5. SEX: MALE
6. COLOR OR RACE: White
7. Married ☐ Never Married ☐ Widowed ☐ Divorced ☒
8. DATE OF BIRTH: 11-8-92
9. AGE (last birthday): 67
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): Bread Truck Driver (ret.)
10b. KIND OF BUSINESS OR INDUSTRY: Bakery
11. BIRTHPLACE (City and state or country): Kansas City, Mo.
12. CITIZEN OF WHAT COUNTRY: U.S.A.

13a. FATHER'S NAME: Henry Dover
13b. MOTHER'S MAIDEN NAME: Jessie Stewart
14. NAME OF HUSBAND OR WIFE:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes (If yes, give war or dates of service) 3-26-17 to 5-7-19
16. SOCIAL SECURITY NO.:
17. INFORMANT: Official Records, VA Hospital K.C., MO. Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute and Chronic bronchopneumonia — 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) Pulmonary fibrosis, emphysema and bronchaectasis

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)
Chronic pyelonephritis

PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
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 ☐ NOT WHILE AT WORK ☐
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. VA attended the deceased from 12-28-59, to 3-21-59 and last saw her/him alive on
Death occurred at 1:00 A m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE S. R. Shane (Degree or title) M.D.
22b. ADDRESS Veterans Hospital Kansas City, Mo.
22c. DATE SIGNED 3-21-60

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE 3-24-60
23c. NAME OF CEMETERY OR CREMATORY Forest Hill Cemetery
23d. LOCATION (City, town, or county) (State) Kansas City, Missouri

24. FUNERAL DIRECTOR Mellody-McGilley-Eylar Funeral Home ADDRESS 1800 E. Linwood Blvd.
25. DATE RECD. BY LOCAL REG. 3-22-60
26. REGISTRAR'S SIGNATURE Neva Minshall

(Licensed Embalmer's Statement on Reverse Side)

BY AFFIDAVIT OF S. R. Shane

DOCUMENT

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 James E. Hackle

Licensed Embalmer No. 457

P. O. Address K. C. M

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to c 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.