

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

=60-014564
STATE FILE NUMBER

FILED VS APR 20 1960

Registration District No. 71 Primary Registration District No. 3012 Registrar's No. 38

1. PLACE OF DEATH a. COUNTY <u>Clay</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>Excelsior Springs,</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>3662 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>76 Veterans Administration Hospital</u>		Length of stay in lb <u>6 Mos, 26 Days</u>	d. STREET ADDRESS (If outside, give location) <u>303 S. Wheeling</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>WILLIAM</u> Middle <u>J</u> Last <u>ZUMWALT</u>			4. DATE OF DEATH Month <u>April</u> Day <u>1</u> Year <u>1960</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</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>10-15-97</u>	9. AGE (In years last birthday) <u>62</u>	IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Truck Driver</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Unknown</u>	11. BIRTHPLACE (City and state or country) <u>Kansas City, Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13a. FATHER'S NAME <u>Merideth Zumwalt</u>		13b. MOTHER'S MAIDEN NAME <u>Nancy J. Critchfield</u>		14. NAME OF HUSBAND OR WIFE <u>Bertha D. Zumwalt</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>Yes WW I</u>		16. SOCIAL SECURITY NO. <u>486 10 4760</u>	17. INFORMANT <u>Bertha D. Zumwalt</u>		Address <u>303 S. Wheeling Kansas City, Mo.</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>Cor Pulmonale</u>					INTERVAL BETWEEN ONSET AND DEATH <u>2 Yrs</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Emphysema</u>					<u>4 Yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Cholecystitis, Acute; Tuberculosis, Pulmonary, Mod. Adv., Active</u>					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.) <u>- - -</u>			
20c. TIME OF INJURY Hour <u>-</u> Month, Day, Year a.m. <u>-</u> p.m. <u>-</u>		20d. INJURY OCCURRED WHILE AT <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>- - -</u>		20f. CITY, TOWN, OR LOCATION <u>- - -</u>		COUNTY <u>- - -</u>	STATE <u>- - -</u>
21. I attended the deceased from <u>Sept. 5, 1959</u> to <u>April 1, 1960</u>					
2. Death occurred at <u>6:05</u> P m on the date stated above; and to the best of my knowledge, from the causes stated. <u>ACD</u>					
22a. SIGNATURE <u>F. J. Mantell</u> <u>F. J. MANTELL, M.D., Actg. Pathologist</u>			22b. ADDRESS <u>VACC, Excelsior Springs, Mo.</u>		22c. DATE SIGNED <u>4/2/60</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>4-2-60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Unknown</u>		23d. LOCATION (City, town, or county) (State) <u>Unknown</u>	
24. FUNERAL DIRECTOR <u>Wurcomers Fun Home</u>		ADDRESS <u>Excelsior Springs, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>4-2-60</u>	26. REGISTRAR'S SIGNATURE <u>Barbara Hutchings</u>	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

VS APR 20 1960 SA

VS JAN 4 1961

APR 26 1960

STATEMENT BY LICENSED EMBALMER

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

Student
Signature of Student Embalmer

Signed *Robert Ray*

Licensed Embalmer No. *4182*

P. O. Address *K.C., Mo.*

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.