

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-015254

STATE FILE NUMBER

FILED VS APR 25 1960 49 Primary Registration District No. 1002 Registrar's No. 1909

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>GREENE</b>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>KANSAS CITY</b>		Length of stay in 1b <b>35 days</b>		c. CITY OR TOWN <b>SPRINGFIELD</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" 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 checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>RR #1 Box 468</b>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>CHARLES</b> Middle <b>LEONARD</b> Last <b>DETHLEFFSEN</b>				4. DATE OF DEATH Month <b>APRIL</b> Day <b>3</b> Year <b>1960</b>				
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>11-20-97</b>	9. AGE (last birthday) <b>62</b>	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) <b>FARMER * RETIRED</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>		11. BIRTHPLACE (City and state or country) <b>San Antonio, Texas</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13a. FATHER'S NAME <b>LEONARD Dethleffsen</b>			13b. MOTHER'S MAIDEN NAME <b>PAULINE MALTZBURGER</b>		14. NAME OF HUSBAND OR WIFE <b>WINNIE</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 I</b>			16. SOCIAL SECURITY NO. <b>500-36-7563</b>		17. INFORMANT <b>Winnie Dethleffsen Rt 1 Springfield, Mo. Official Records VA Hospital, K.C., Mo.</b>			Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:							INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) <b>Aspiration pneumonia</b>								
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.								
DUE TO (b) <b>Tracheo-bronchial fistula</b>								
DUE TO (c) <b>Carcinoma of esophagus</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			
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 Month, Day, Year a.m. p.m.								
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
21. attended the deceased from <b>February 28, 1960</b> to <b>April 3, 1960</b> Death occurred at <b>4:40 P.M.</b> on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE <b>J. A. TURNER, M.D.</b>				22b. ADDRESS <b>VA Hospital, K.C., Mo.</b>			22c. DATE SIGNED <b>4-4-60</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>4-4-60</b>	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) <b>Austin, Texas</b>		(State)		
24. FUNERAL DIRECTOR ADDRESS <b>Klinger Funeral Home, Spgfield, Mo.</b>				25. DATE RECD. BY LOCAL REG. <b>4-4-60</b>		26. REGISTRAR'S SIGNATURE <b>Neve Marshall</b>		

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 Alvin R. Hancock

Licensed Embalmer No. 415  
P. O. Address J. E.

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