

JRL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-015275

FILED VS MAY 16 1960

2325

STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 2325

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Kansas</b> b. COUNTY <b>Johnson</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kansas City</b>		c. CITY OR TOWN <b>Shawnee</b>	
Length of stay in 1b <b>4 days</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</b>		d. STREET ADDRESS (If outside, give location) <b>6908 Halsey Drive</b>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <b>EDDIE</b> Middle <b>ALDERSON</b> Last <b>DUVALL</b>			4. DATE OF DEATH Month <b>4th</b> Day <b>23rd</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>12-25-1914</b>	9. AGE (last birthday) <b>45</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>Chiropractor</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Meadow View, Virginia</b>	11. BIRTHPLACE (City and state or country) <b>U.S.A.</b>	12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>
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13a. FATHER'S NAME <b>William E. Duvall</b>	13b. MOTHER'S MAIDEN NAME <b>Mary Nancy Alderson</b>	14. NAME OF HUSBAND OR WIFE <b>Anna C. Duvall</b>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes WWI</b>	16. SOCIAL SECURITY NO. <b>531-14-8366</b>	17. PLACE OF DEATH <b>VA Hospital, Shawnee, Kansas</b>

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>Myocardial infarction, old and recent</b>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>Thrombosis, left coronary artery</b>	
	DUE TO (c) <b>Arteriosclerosis, coronary arteries</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.)
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20c. TIME OF INJURY Hour <b>6:55 p.</b> Month, Day, Year <b>4-19-60</b>	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 <b>VA Hospital, Shawnee, Kansas</b>
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21. I attended the deceased from **4-19-60** to **4-23-60**  
Death occurred at **6:55 p.** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <i>J. A. Turner</i>	(Degree or title) <b>M.D.</b>	22b. ADDRESS <b>VA Hospital, K. C. Mo.</b>	22c. DATE SIGNED <b>4-24-60</b>
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23a. BURIAL REMOVAL, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE <b>APRIL 28, 1960</b>	23c. NAME OF CEMETERY OR CREMATORY <b>NATIONAL CEM.</b>	23d. LOCATION (City, town, or county) (State) <b>LEAVENWORTH KANSAS</b>
24. FUNERAL DIRECTOR <b>D. W. NEWCOMER'S SONS KC. MO.</b>		25. DATE RECD. BY LOCAL REG. <b>4-26-60</b>	26. REGISTRAR'S SIGNATURE <i>Neva Minshall</i>

9-19-60  
 DOCUMENT  
 65  
 BY AFFIDAVIT OF INFORMATION  
 65  
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J. A. Turner  
 MEDICAL CERTIFICATION

**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

*[Handwritten Signature]*

Licensed Embalmer No. 4421

P. O. Address Kansas

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