

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH  
 FILED VS MAY 16 1960

-60-015343

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 2327 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Kansas</u> b. COUNTY <u>Johnson</u>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kansas City</u>		Length of stay in 1b <u>18 days</u>		c. CITY OR TOWN <u>Olathe,</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>V.A. Hospital</u>			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>219 W. Poplar</u>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Otto</u> Middle <u>Frederick</u> Last <u>Gras</u>				4. DATE OF DEATH Month <u>4th</u> Day <u>26th</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>5-4-89</u>	9. AGE (last birthday) <u>70 yrs</u>	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)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>Olathe, Kansas</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.</u>	
13a. FATHER'S NAME <u>William Gras</u>			13b. MOTHER'S MAIDEN NAME <u>Verona Bartholl</u>			14. NAME OF HUSBAND OR WIFE <u>Betty Gras</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes 5/14/18 to 8/7/19</u>			16. SOCIAL SECURITY NO.		17. INFORMANT <u>Betty Gras, Olathe, Kansas (Wife)</u> <u>V.A. Hospital Records, K.C., Mo.</u>			
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) <u>Hemorrhaging esophageal varicies</u>								
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.								
DUE TO (b)								
DUE TO (c) <u>Cirrhosis of the liver</u>								
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 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 a.m. p.m.		Month, Day, Year						
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
<u>VA</u>				<u>V.A.</u>		<u>Kansas</u>		<u>Mo</u>
21. I attended the deceased from <u>April 8, 1960</u> to <u>April 26, 1960</u> Death occurred at <u>1:45a</u> on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) <u>Robert W. Brown</u>				22b. ADDRESS <u>MD V.A. Hospital, Kansas City, Mo</u>			22c. DATE SIGNED <u>4/26/60</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)			
<u>Removal</u>		<u>4-26-60</u>	<u>Olathe Cemetery</u>		<u>Olathe Kansas</u>			
24. FUNERAL DIRECTOR <u>Robert W. Brown</u>				25. DATE RECD. BY LOCAL REG. <u>4-26-60</u>		26. REGISTRAR'S SIGNATURE <u>Neva Marshall</u>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATE OF IOWA

**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 *Matthew Fry*, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed *Matthew Fry*

Licensed Embalmer No. 3615

P. O. Address *Platteville*

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.