

DEPARTMENT OF HEALTH - STANDARD CERTIFICATE OF DEATH

60-015350

DED

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 2397 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY JACKSON		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY Linn	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN KANSAS CITY		Length of stay in 1b 16 days	c. CITY OR TOWN BUCKLIN Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION V A HOSPITAL		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) ROUTE 1 Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First ARTHUR Middle Last GROSS			4. DATE OF DEATH Month April Day 27 Year 1960		
5. SEX Male	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 2-10-88	9. AGE (last birthday) 72	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) Retired		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Richmond, Missouri	12. CITIZEN OF WHAT COUNTRY U.S.A.	

13a. FATHER'S NAME Unknown		13b. MOTHER'S MAIDEN NAME Unknown		14. NAME OF HUSBAND OR WIFE Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WWI		16. SOCIAL SECURITY NO. —		17. INFORMANT VA Hospital Official Reds, K.C. Mo Mrs. Billy Ralls, 214 Grove St. Chillicothe Mo.	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Peritonitis			INTERVAL BETWEEN ONSET AND DEATH Mo.
DUE TO (b) Separation; gastro-jejuno-stomy, suture line			
DUE TO (c) Peptic gastric ulcer - post operative status			

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	
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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 a.m. p.m. Month, Day, Year			

20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION VA Hospital, Kansas City, Mo.	COUNTY Mo.	STATE
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21. I attended the deceased from **April 11, 1960** to **April 27, 1960** and last saw him alive on **April 27, 1960**
Death occurred at **7:37 P** m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE S. A. Turner, M.D.	22b. ADDRESS VA Hospital, Kansas City, Mo.	22c. DATE SIGNED 4-28-60
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23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 4/29/1960	23c. NAME OF CEMETERY OR CREMATORY Camel Cemetery	23d. LOCATION (City, town, or county) (State) Milann Missouri
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24. FUNERAL DIRECTOR W. Newcomers Sons 1331 Brush Creek Blvd. Kansas City Missouri	25. DATE RECD. BY LOCAL REG. 4-29-60	26. REGISTRAR'S SIGNATURE Paula Winifall
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATE OF MISSISSIPPI
 DEPARTMENT OF HEALTH
 BUREAU OF HEALTH OFFICERS
 MEMPHIS, TENNESSEE

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 *E. D. Nelson*

 Licensed Embalmer No. 4481
 P. O. Address K. C. Mc

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.