I DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

FILED VS MAY 5 1960

-60-015374
STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 2104

1. PLACE OF DEATH a. COUNTY JACKSON	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE KANSAS b. COUNTY FRANKLIN
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN KANSAS CITY — Length of stay in Ib: 14 days	c. CITY OR TOWN WELLSVILLE — Inside Limits: Yes ☒ No ☐
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION VA Hospital, K.C.,Mo. — Inside Limits: Yes ☒ No ☐	d. STREET ADDRESS (If outside, give location) — Reside on Farm: Yes ☐ No ☒

3. NAME OF DECEASED (Type or print)	First: RALPH	Middle: HENRY	Last: HAY	4. DATE OF DEATH	Month: APRIL Day: 13, Year: 1960
5. SEX: MALE	6. COLOR OR RACE: WHITE	7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐	8. DATE OF BIRTH: 5-26-88	9. AGE (last birthday): 71	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): BLACKSMITH	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country): WELLSVILLE, KANSAS	12. CITIZEN OF WHAT COUNTRY: U.S.A.		
13a. FATHER'S NAME: JOHN HAY	13b. MOTHER'S MAIDEN NAME: CARRIE HOLSBERG	14. NAME OF HUSBAND OR WIFE: PAULINE			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): YES (If yes, give war or dates of service): WW I	16. SOCIAL SECURITY NO.: —	17. INFORMANT: PAULINE HAY, WIFE, WELLSVILLE, KANSAS — Address: OFFICIAL RECORDS VA HOSPITAL, K.C., MO.			

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Pulmonary congestion ; right hydrothorax

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b) Gastric aspiration

DUE TO (c) Portal cirrhosis

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

Pulmonary vesicular emphysema

PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

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 ☐ NOT WHILE AT WORK ☐

20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION COUNTY STATE

VA

21. I attended the deceased from March 30, 60, to April 13, 1960 and last saw him alive on

Death occurred at 8:32 P.M. m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE J. A. TURNER, M.D. (Degree or title) — J. A. Turner M. D.

22b. ADDRESS VA Hospital, K.C., Mo.

22c. DATE SIGNED 4-14-60

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal

23b. DATE 4-14-60

23c. NAME OF CEMETERY OR CREMATORY Wellsville, Ks. Cem.

23d. LOCATION (City, town, or county) (State) Wellsville, Kansas

24. FUNERAL DIRECTOR ADDRESS Stine & McClure, Kansas City, Mo.

25. DATE RECD. BY LOCAL REG. 4-14-60

26. REGISTRAR'S SIGNATURE Neva Minshall

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

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 Joe B. Yoder

Licensed Embalmer No. 4173

P. O. Address K.C. Mo

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