

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-019584

FILED VS MAY 27 1960

149

Registration District No. _____ Primary Registration District No. **1002** Registrar's No. **2725**

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 Greene	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN KANSAS CITY		Length of stay in 1b 2 hrs.	c. CITY OR TOWN SPRINGFIELD 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) 2017 ALBERTHA STREET Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First JESS Middle M Last PRESNELL			4. DATE OF DEATH Month May Day 18 Year 1960		
5. SEX Male	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 6-20-11	9. AGE (last birthday) 48	IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Disabled	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Ebenezer, Missouri	12. CITIZEN OF WHAT COUNTRY U.S.A.
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13a. FATHER'S NAME Martin Presnell	13b. MOTHER'S MAIDEN NAME Katie Smith	14. NAME OF HUSBAND OR WIFE none
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes	16. SOCIAL SECURITY NO. 500-10-0713	17. INFORMANT VA Hospital Official Rcds, K.C. Mo. Edna McCrum 2041 Albertha Ave. Springfield,
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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) Carcinoma of larynx		Mo.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b)	
	DUE TO (c)	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Arrested pulmonary tuberculosis	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 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 _____ 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 VA	COUNTY _____ STATE _____
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21. I attended the deceased from **January 13, 1960** to **May 18, 1960** ~~xxxxxxxxxxxx~~
Death occurred at **10.55** **a.m.** on the date stated above, and to the best of my knowledge, from the causes stated.

22. SIGNATURE (Degree or title) HARRY A. KNAUFF, M.D.	22b. ADDRESS VA Hospital, Kansas City, Mo.	22c. DATE SIGNED 5-18-60
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23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 5-18-1960	23c. NAME OF CEMETERY OR CREMATORY Robberson Prairie	23d. LOCATION (City, town, or county) (State) Springfield, Mo
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24. FUNERAL DIRECTOR Wagner Funeral Home, 756 Mo	ADDRESS	25. DATE RECD. BY LOCAL REG. 5-18-60	26. REGISTRAR'S SIGNATURE Wera Marshall
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATE OF KANSAS
DEPARTMENT OF HEALTH
BUREAU OF HEALTH
DIVISION OF ANATOMY
AND EMBALMING
CERTIFICATE OF EMBALMING
No. _____
Date _____
Name of Deceased _____
Age _____
Sex _____
Color _____
Place of Birth _____
Date of Death _____
Cause of Death _____
Place of Death _____
Name of Embalmer _____
Address _____
City _____
State _____
Zip _____
Signature of Embalmer _____
Date _____

STATEMENT BY LICENSED EMBALMER

MAY 31 1980

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. Havens

Licensed Embalmer No. 415
P. O. Address Kansas

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.