

# URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

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STATE FILE NUMBER

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Registration District No. Primary Registration District No. Registrar's No.

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|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Buchanan</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                   |                                                                                      | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Missouri</b> b. COUNTY <b>Jackson</b>                  |                                                                        |                                                                                      |                                                                                       |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <b>St. Joseph</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | Length of stay in 1b<br><b>2 years</b>                                                                            |                                                                                      | c. CITY OR TOWN <b>Kansas City</b>                                                                                                                          |                                                                        | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |                                                                                       |  |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <b>State Hospital #2</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                   | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |                                                                                                                                                             | d. STREET ADDRESS (If outside, give location)<br><b>1315 West 39th</b> |                                                                                      | Reside on Farm<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |  |
| 3. NAME OF DECEASED<br>(Type or print)<br>First <b>JOHN</b> Middle <b>L.</b> Last <b>DAWSON</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                   |                                                                                      | 4. DATE OF DEATH<br>Month <b>August</b> Day <b>12</b> Year <b>1960</b>                                                                                      |                                                                        |                                                                                      |                                                                                       |  |
| 5. SEX<br><b>male</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 6. COLOR OR RACE<br><b>white</b>                                                                                  |                                                                                      | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> |                                                                        | 8. DATE OF BIRTH<br><b>4-4-1924</b>                                                  |                                                                                       |  |
| 9. AGE (last birthday)<br><b>36</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | IF UNDER 1 YEAR<br>Months Days                                                                                    |                                                                                      | IF UNDER 24 HR<br>Hours Min.                                                                                                                                |                                                                        |                                                                                      |                                                                                       |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>truck driver, mechanic</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                   |                                                                                      | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Agency, Missouri</b>                                                                                                |                                                                        | 12. CITIZEN OF WHAT COUNTRY<br><b>U.S.A.</b>                                         |                                                                                       |  |
| 13a. FATHER'S NAME<br><b>Walter Dawson</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                   |                                                                                      | 13b. MOTHER'S MAIDEN NAME<br><b>Agnes Johnson</b>                                                                                                           |                                                                        | 14. NAME OF HUSBAND OR WIFE<br><b>Florine Dawson</b>                                 |                                                                                       |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes, give war and dates of service)<br><b>yes W.W. II</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                   |                                                                                      | 16. SOCIAL SECURITY NO.<br><b>486-26-8049</b>                                                                                                               |                                                                        | 17. INFORMANT<br><b>Records, State Hospital #2, St. Joseph</b>                       |                                                                                       |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Pulmonary Embolism</b><br>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.<br>DUE TO (b) <b>Phlebo thrombosis left leg</b><br>DUE TO (c) _____<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)<br>PART III. If deceased was female was there a pregnancy in last 90 days.<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |  |                                                                                                                   |                                                                                      |                                                                                                                                                             |                                                                        |                                                                                      | INTERVAL BETWEEN ONSET AND DEATH                                                      |  |
| 19. WAS AUTOPSY PERFORMED?<br>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<br>Hour <b>1:25</b> a.m. p.m.<br>Month, Day, Year <b>5-25-1960</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 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.)<br><b>8-12-1960</b>                                                |                                                                        | 20f. CITY, TOWN, OR LOCATION<br><b>8-12-1960</b>                                     |                                                                                       |  |
| 20g. COUNTY<br><b>8-12-1960</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 20h. STATE                                                                                                        |                                                                                      |                                                                                                                                                             |                                                                        |                                                                                      |                                                                                       |  |
| 21. I attended the deceased from <b>5-25-1960</b> to <b>8-12-1960</b> and last saw him alive on <b>8-12-1960</b><br>Death occurred at <b>1:25 A.M.</b> on the date stated above, and to the best of my knowledge, from the causes stated.                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                   |                                                                                      |                                                                                                                                                             |                                                                        |                                                                                      |                                                                                       |  |
| 22a. SIGNATURE<br><i>Musthammad Tahir M.D.</i> (Degree or title)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                   |                                                                                      | 22b. ADDRESS<br><b>State Hospital #2, St. Joseph</b>                                                                                                        |                                                                        | 22c. DATE SIGNED<br><b>8-12-1960</b>                                                 |                                                                                       |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  | 23b. DATE<br><b>Aug. 16, 1960</b>                                                                                 |                                                                                      | 23c. NAME OF CEMETERY OR CREMATORY<br><b>National Cemetery</b>                                                                                              |                                                                        | 23d. LOCATION (City, town, or county) (State)<br><b>Ft. Leavenworth, Kansas</b>      |                                                                                       |  |
| 24. FUNERAL DIRECTOR<br><b>Newcomers Sons-Brush Creek &amp; Paseo</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                   |                                                                                      | 25. DATE RECD. BY LOCAL REG.<br><b>Aug 12, 1960</b>                                                                                                         |                                                                        | 26. REGISTRAR'S SIGNATURE<br><i>Wm. Clark Standell</i>                               |                                                                                       |  |
| ADDRESS<br><b>Kansas City, Mo</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                   |                                                                                      | Licensed Embalmer's Statement on Reverse Side)                                                                                                              |                                                                        |                                                                                      |                                                                                       |  |

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

*M. Tahir, M.D.*

AUG 23 1960

JUL 13 1962

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me

or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_

Signature of Student Embalmer

Signed \_\_\_\_\_

*E. L. Gibson*

Licensed Embalmer No. 4137

*Excelsior Sp, Mo*

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.