

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS AUG 23 1960

4015-60-030618
STATE FILE NUMBER

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

DED

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE-(Where deceased lived. If institution: Residence before admission) a. STATE Kansas b. COUNTY Leavenworth	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City		Length of stay in lb 1 day	c. CITY OR TOWN Leavenworth, Ks Inside Limits Yes <input checked="" 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) 1016 Delaware Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) JAMES L. KEATING			4. DATE OF DEATH Month 8th Day 2nd 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 7-4-85	9. AGE (last birthday) 75 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Miner		10b. KIND OF BUSINESS OR INDUSTRY Mining	11. BIRTHPLACE (City and state or country) Oswego, N.Y.	12. CITIZEN OF WHAT COUNTRY U.S.A.

13a. FATHER'S NAME John H. Keating	13b. MOTHER'S MAIDEN NAME Nellie Ryan	14. NAME OF HUSBAND OR WIFE None
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. RR#557 22 2427	17. INFORMATION FROM WOM Wadsworth, Kansas VA Hospital Records, K.C., Mo

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) Cerebral trauma, diffuse		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Fracture of left temporal bone of skull with subarachnoid hemorrhages	
	DUE TO (c)	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Fractures of left 3,4,5 ribs, 1st lumbar vertebra	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.) Probably Hit by Auto??
20c. TIME OF INJURY Hour Unknown a.m. 8-2-60 p.m.		

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.) Highway	20f. CITY, TOWN, OR LOCATION Near Leavenworth - Leavenworth, Kans.	COUNTY	STATE
21. I attended the deceased from August 2, 1960 to August 2, 1960 Death occurred at 11:00 p m on the date stated above, and to the best of my knowledge, from the causes stated.				

22a. SIGNATURE (Degree or title) Hugh H. Newcomer		22b. ADDRESS 153 Union Station	22c. DATE SIGNED 8-4-60
23a. BURIAL OR CREMATION, REMOVED (Specify) BURIAL	23b. DATE AUGUST 5, 1960	23c. NAME OF CEMETERY OR CRYPTORY NATIONAL CEMETERY	23d. LOCATION (City, town, or county) (State) FORT LEAVENWORTH KANSAS
24. FUNERAL DIRECTOR D. W. NEWCOMER'S SONS KANSAS CITY, MO.		25. DATE RECD. BY LOCAL REG. 8-5-60	26. REGISTRAR'S SIGNATURE H. L. Dwyer, M.D.

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF
Hug H. Newcomer

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed

Marvin J. Preston

Licensed Embalmer No. _____

P. O. Address _____

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