

UNFILED DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH
 FILED VS OCT 1 0 1960

4838-60-034888
 STATE FILE NUMBER

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

1. PLACE OF DEATH a. COUNTY JACKSON		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY JACKSON	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN KANSAS CITY		Length of stay in 1b 11 years	c. CITY OR TOWN KANSAS CITY 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) 701 WEST 74TH STREET Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First JOHN Middle BERNARD Last MC DANIEL			4. DATE OF DEATH Month September Day 23 Year 1960			
5. SEX Male	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 1-14-15	9. AGE (last birthday) 45	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) Gas service company		10b. KIND OF BUSINESS OR INDUSTRY OPERATOR		11. BIRTHPLACE (City and state or country) Slidell, Louisiana		12. CITIZEN OF WHAT COUNTRY U.S.A.
13a. FATHER'S NAME JOHN McDANIEL		13b. MOTHER'S MAIDEN NAME LILLA VICERY		14. NAME OF HUSBAND OR WIFE JUANITA Elmaline/McDaniel		

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WWII	16. SOCIAL SECURITY NO. 435-20-7780	17. INFORMANT VA Hospital Official Rcds, K.C. Mo. Elmaline McDaniels, 701 W.74 St, K.C. Mo.
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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: IMMEDIATE CAUSE (a) Cerebral hemorrhage, left frontal		INTERVAL BETWEEN ONSET AND DEATH
DUE TO (b) Rupture of aneurysm, left cerebral artery		
DUE TO (c) _____		
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

19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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 COUNTY STATE

21. Attended the deceased from **August 23, 1960** to **September 23, 1960**
 Death occurred at **3:30 p** m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) R. H. Owings M.D.	22b. ADDRESS VA Hospital, Kansas City, Mo.	22c. DATE SIGNED 9-23-60
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL	23b. DATE SEPT. 24, 1960	23c. NAME OF CEMETERY OR CREMATORY CARRIERE MISSISSIPPI

24. FUNERAL DIRECTOR D. W. NEWCOMER'S SONS	ADDRESS 1331 BRUSH CREEK KANSAS CITY, MO.	25. DATE RECD. BY LOCAL REG. 9-24-60	26. REGISTRAR'S SIGNATURE H. L. Owyer
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DOCUMENT
MEDICAL CERTIFICATION
BY AFFIDAVIT OF R. H. Owings

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 Raymond M. Haro

Licensed Embalmer No. 491-

P. O. Address Indep.

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.