

IRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS OCT 27 1960

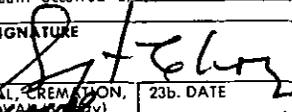
-60-028349

4886

STATE FILE NUMBER

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

NDED

1. PLACE OF DEATH a. COUNTY JACKSON b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN KANSAS CITY Length of stay in 1b 34 days 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"/>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY St. Clair c. CITY OR TOWN OSCEOLA Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) _____ Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First JAMES Middle J Last EMIGH			4. DATE OF DEATH Month September Day 26 Year 1960				
5. SEX Male	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>	8. DATE OF BIRTH 5-8-16	9. AGE (last birthday) 44	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) Retired Air force		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (City and state or country) Helena Arkansas			
12. CITIZEN OF WHAT COUNTRY U.S.A.		13a. FATHER'S NAME John Emigh		13b. MOTHER'S MAIDEN NAME Maggie _____			
14. NAME OF HUSBAND OR WIFE _____		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes PL 28		16. SOCIAL SECURITY NO. 491 40 9192			
17. INFORMANT VA Hospital Official Rcds, K.C. Mo. William Emigh 704 Glendale, Houston, Tex.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchogenic carcinoma with extensive direct extension to mediastinum and neck. DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. _____ 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 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 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.) VA	20f. CITY, TOWN, OR LOCATION _____	COUNTY _____	STATE _____		
21. Attended the deceased from August 23, 1960 September 26, 1960 Death occurred at 10:30 a.m. on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE 			22b. ADDRESS VA Hospital, Kansas City, Mo.		22c. DATE SIGNED 9-26-60		
23a. BURIAL, CREMATION, OR OTHER DISPOSITION Burial	23b. DATE 9-27-60	23c. NAME OF CEMETERY OR CREMATORY National		23d. LOCATION (City, town, or county) Springfield	(State) Mo		
24. FUNERAL DIRECTOR Goodrich Funeral Home		ADDRESS Osceola Mo		25. DATE RECD. BY LOCAL REG. 9-28-60	26. REGISTRAR'S SIGNATURE 		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

DEC 2 1960

JAN 12 1961

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 J B Bandwidth

Licensed Embalmer No. 303

P. O. Address Orceel

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.