

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

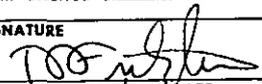
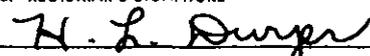
-60-041984

FILED VS NOV 17 1960

5471

STATE FILE NUMBER

Registration District No. \_\_\_\_\_ Primary Registration District No. 1002 Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Kansas</b> b. COUNTY <b>Wyandotte</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <b>Kansas City</b>		c. CITY OR TOWN <b>1024 S. 46th Terr</b>	
Length of stay in 1b <b>18 days</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>V.A. Hospital</b>		d. STREET ADDRESS (If outside, give location) <b>Kansas City</b>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>LELAND J. FELSHAW</b>			4. DATE OF DEATH Month Day Year <b>10th 29th 1960</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>4-29-06</b>
9. AGE (last birthday) <b>54 yrs</b>		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) <b>Laborer Stock-Room</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Jensen-Salsbery Construction</b>	11. BIRTHPLACE (City and state or country) <b>Des Moines, Iowa</b>
12. CITIZEN OF WHAT COUNTRY <b>U.S.</b>		13a. FATHER'S NAME <b>Roy Felshaw</b>	
13b. MOTHER'S MAIDEN NAME <b>Mollie Babb</b>		14. NAME OF HUSBAND OR WIFE <b>Lucienne Felshaw</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes WWII</b>		16. SOCIAL SECURITY NO. <b>564 16 1779</b>	
17. <b>Lucienne Felshaw, wife - Same as above</b>		17. <b>V.A. Hospital, Kansas City, Mo</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Abdominal carcinomatosis</b> DUE TO (b) <b>Carcinoma of the rectum</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>bilateral pyelonephritis, advanced</b>			INTERVAL BETWEEN ONSET AND DEATH
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. <input checked="" type="checkbox"/> attended the deceased from <b>October 11, 1960</b> to <b>October 29, 1960</b> and last saw him alive on <b>October 29, 1960</b>		Death occurred at <b>7:15a</b> m on the date stated above, and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE  (Degree or title)		22b. ADDRESS <b>MD V.A. Hospital, Kansas City, Mo</b>	22c. DATE SIGNED <b>10-29-60</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>10/31/60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mt Hope Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Kansas City, Kansas</b>
24. FUNERAL DIRECTOR <b>JOS. A. BUTLER'S SONS K.C.K</b>		25. DATE RECD. BY LOCAL REG. <b>10-31-60</b>	26. REGISTRAR'S SIGNATURE 

DOCUMENT

BY AFFIDAVIT OF T.J. Fritz Medical Certification MD

**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 Russell W. [Signature]

Licensed Embalmer No. 3462

P. O. Address Kansas City

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