

# RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-045923

OF PUBLIC HEALTH AND WELFARE

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 6278 STATE FILE NUMBER

FILED VS JAN 11 1961

IDED

DOCUMENT

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Jackson</b>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kansas City</b>		Length of stay in 1b <b>48 yrs</b>		c. CITY OR TOWN <b>Kansas City</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>1506 E. 22nd Terr</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>George</b> Middle <b>Henry</b> Last <b>Bly</b>			4. DATE OF DEATH Month <b>12th</b> Day <b>13th</b> Year <b>1960</b>				
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</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>4-14-91</b>	9. AGE (last birthday) <b>69 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>Porter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Maintenance</b>		11. BIRTHPLACE (City and state of country) <b>Fayette, Mo</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.</b>	
13a. FATHER'S NAME <b>Hub Bly</b>		13b. MOTHER'S MAIDEN NAME <b>Alice McKenney</b>		14. NAME OF HUSBAND OR WIFE <b>Alene Bly</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes</b>			16. SOCIAL SECURITY NO. <b>495-03-9472</b>		17. INFORMANT <b>Alene Bly, wife, Kansas City, Mo</b> <i>Address</i> <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:						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b>							
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.							
DUE TO (b) <b>Carcinoma of right lung.</b>							
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 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. I attended the deceased from <b>October 30, 1960</b> to <b>December 13, 1960</b> and was present her death occurred at <b>10:30 p.m.</b> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <b>William B. Neel</b> (Degree or title) <i>William B. Neel, M.D.</i>				22b. ADDRESS <b>V.A. Hospital, Kansas City, Mo</b>		22c. DATE SIGNED <b>12-13-60</b>	
23a. BURIAL, CREMATION, (REMOVAL) (Specify) <b>burial</b>		23b. DATE <b>12-19-60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>National</b>		23d. LOCATION (City, town, or county) (State) <b>Ft. Leavenworth, Kansas</b>		
24. FUNERAL DIRECTOR <b>Watkins Bros. Funeral Home 18th Benton</b>				25. DATE RECD. BY LOCAL REG. <b>12-14-60</b>		26. REGISTRAR'S SIGNATURE <i>H.L. Dwyer</i>	

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**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 Bruce A. Watkins

Licensed Embalmer No. 458

P. O. Address 1st Bar

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.