

R I DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-046204

FILED VS. DEC 3 0 1960

149

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

6174

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kansas City</u>		Length of stay in lb <u>32 yrs</u>	c. CITY OR TOWN <u>Kansas City</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Research Hospital</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>4535 Roanoke Pky</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>LeRoy James McPheeters</u>			4. DATE OF DEATH Month Day Year <u>12 6 1960</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>9-4-1909</u>	9. AGE (last birthday) <u>51</u>	IF UNDER 1 YEAR Months Days <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Medical Supplies</u>	11. BIRTHPLACE (City and state or country) <u>Omaha, Neb.</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>William J. McPheeters</u>		13b. MOTHER'S MAIDEN NAME <u>Florence Fleming</u>		14. NAME OF HUSBAND OR WIFE <u>Viola D. McPheeters</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>495-03-2005</u>	17. INFORMANT <u>Wife</u>		Address <u>Home</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Meningeal Subdural Hemorrhage</u> DUE TO (b) <u>Fractured Skull</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH	
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 checked="" 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.) <u>car struck corner stop street</u>				
20c. TIME OF INJURY Hour <u>12:40</u> a.m. Month, Day, Year <u>11-28-60</u>	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.) <u>Street</u>	20f. CITY, TOWN, OR LOCATION <u>Kansas City</u>		COUNTY STATE <u>Jackson Mo.</u>	
21. I attended the deceased from _____ to _____ and last saw him alive on _____ Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.						
22. SIGNATURE (Degree or title) <u>Geo. C. Kealhofer, M.D., Deputy Coroner</u>			22b. ADDRESS <u>6627 Vermont St, Overland Park, Mo.</u>		22c. DATE SIGNED <u>12-7-60</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>12-9-1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Moriah</u>		23d. LOCATION (City, town, or county) (State) <u>Kansas City Mo.</u>		
24. FUNERAL DIRECTOR <u>Mellody-McGilley-Eylar</u>		ADDRESS <u>Linwood 20 W.</u>	25. DATE RECD. BY LOCAL REG. <u>12-8-60</u>	26. REGISTRAR'S SIGNATURE <u>H-L. Dwyer</u>		

DOCUMENT

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 by
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer .

Signed

Floyd J. Dickson

Licensed Embalmer No. 5120

P. O. Address K.C. Mo.

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