

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-61-005518  
STATE FILE NUMBER

AMENDED

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 733

**FILED VS MAR 1 1961**

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>40 years</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>VA HOSPITAL, K.C., MO.</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>2751 CHARLOTTE STREET</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>VERN</b> Middle <b>ALLEN</b> Last <b>SHEETS</b>			4. DATE OF DEATH Month <b>FEBRUARY</b> Day <b>9</b> Year <b>1961</b>		
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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>5-8-94</b>	9. AGE (last birthday) <b>66</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>BUS DRIVER * RETIRED</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>TRANSIT KANSAS CITY</b>	11. BIRTHPLACE (City and state or country) <b>MERCER COUNTY, MO.</b>	12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>
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13a. FATHER'S NAME <b>ULYSSES S. GRANT SHEETS</b>	13b. MOTHER'S MAIDEN NAME <b>LUCY B. SCOTT</b>	14. NAME OF HUSBAND OR WIFE <b>CECIL</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)  
**YES WW I**  
 Informant: **Cecil Sheets Wife 2751 Charlotte, K.C., Mo. Official Records VA Hospital, K.C., Mo.**

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
 PART I. DEATH WAS CAUSED BY:  
 IMMEDIATE CAUSE (a) **Peritonitis**  
 DUE TO (b) **Sub-phrenic abscess**  
 DUE TO (c) **Post-operative status, subtotal gastrectomy** 11 days  
 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)  
**Atherosclerosis, generalized, severe**

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.)
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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 _____
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21. **NA** attended the deceased from **January 17, 1961** to **February 9, 1961**  
 Death occurred at **6:25 P.M.** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <i>R. H. Owings, M.D.</i>	22b. ADDRESS <b>VA Hospital, K.C., Mo.</b>	22c. DATE SIGNED <b>2-10-61</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE <b>FEB. 11, 1961</b>	23c. NAME OF CEMETERY <b>GREEN LAWN CEMETERY</b>	23d. LOCATION (City, town, or county) <b>KANSAS CITY MISSOURI</b>
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24. FUNERAL DIRECTOR <b>D.W. NEWCOMER'S SONS</b>	ADDRESS <b>1331 BRUSH CREEK KANSAS CITY, MO.</b>	25. DATE RECD. BY LOCAL REG. <b>2-11-61</b>	26. REGISTRAR'S SIGNATURE <i>Ruth Long</i>
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(Licensed Embalmer's Statement on Reverse Side)

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS  
 INSTEAD OF  
 DOCUMENT  
 MEDICAL CERTIFICATION  
 BY AFFIDAVIT OF  
 ITEM NO. SHOULD READ

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_

Signature of Student Embalmer

Signed

*Bill J. Honey*

Licensed Embalmer No. 2724

P. O. Address A.C. M.

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.