SOURI DIVISION OF HEALTH — STANDARD CERTIFICATE OF DEATH

MENT OF PUBLIC HEALTH AND WELFARE

172 2-61-021350

STATE FILE NUMBER

AMENDED

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 2722

FILED JUN 21 1961

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

BY AFFIDAVIT OF

1. PLACE OF DEATH
a. COUNTY JACKSON
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN KANSAS CITY, MISSOURI — Length of stay in 1b: 63 days
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION VA HOSPITAL, K.C., MO. — Inside Limits: Yes ☐ No ☒

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MISSOURI b. COUNTY JACKSON
c. CITY OR TOWN KANSAS CITY, MO. — Inside Limits: Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location) 7719 E 55th St. — Reside on Farm: Yes ☐ No ☒

3. NAME OF DECEASED (Type or print): First CARL Middle JAMES Last McCAULEY

4. DATE OF DEATH: Month May Day 30 Year 1961

5. SEX: Male
6. COLOR OR RACE: White
7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐
8. DATE OF BIRTH: 8/26/08
9. AGE (last birthday): ~~53~~ 52
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): Auto Mechanic
10b. KIND OF BUSINESS OR INDUSTRY: GARAGE
11. BIRTHPLACE (City and state or country): KANSAS CITY, KS.
12. CITIZEN OF WHAT COUNTRY: U.S.A.

13a. FATHER'S NAME: James McCauley
13b. MOTHER'S MAIDEN NAME: Unknown
14. NAME OF HUSBAND OR WIFE: Margaret McCauley

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): 2/23/44 to 11/28/45
16. SOCIAL SECURITY NO.
17. INFORMANT: VA Hospital Records. Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Meningitis, etiology undeterm ined
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b)
DUE TO (c)
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. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
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 ☐ NOT WHILE AT WORK ☐
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 Mar 28, 1961 to May 30, 1961 and last saw him alive on May 30, 1961
Death occurred at 6:15 PM 5/30/61 on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE R. H. Owings, M.D. (Degree or title) — R. H. Owings, M.D.
22b. ADDRESS VA Hospital, Kansas City, Mo.
22c. DATE SIGNED 5-31-61

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial.
23b. DATE June 2. 1961
23c. NAME OF CEMETERY OR CREMATORY Floral Hills Cemetery
23d. LOCATION (City, town, or county) (State) Raytown, Mo.

24. FUNERAL DIRECTOR Clark Hegent
ADDRESS Raytown Mo.
25. DATE RECD. BY LOCAL REG. 6-1-61
26. REGISTRAR'S SIGNATURE Ruth Long

(Licensed Embalmer's Statement on Reverse Side)

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_____ Signed John M. Kalsbeek

Signature of Student Embalmer

Licensed Embalmer No. 4949

P. O. Address No. Kansas

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