

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=61-036850

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 5258

STATE FILE NUMBER

AMENDED

FILED NOV 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>10 years</b>	c. CITY OR TOWN <b>KANSAS CITY</b> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>V A HOSPITAL</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>3105 PROSPECT</b> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>LIONEL</b> Middle <b>HORATIUS</b> Last <b>COTTON</b>			4. DATE OF DEATH Month <b>October</b> Day <b>20</b> Year <b>1961</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>10-7-05</b>	9. AGE (last birthday) <b>56</b>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Bar tender</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>Atlanta, Georgia</b>	12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13a. FATHER'S NAME <b>John Cotton</b>		13b. MOTHER'S MAIDEN NAME <b>Bessie Roberts</b>		14. NAME OF HUSBAND OR WIFE <b>--</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>unk.</b>	17. INFORMANT <b>VA Hospital Official Records, K.C. Mo.</b>
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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>MYOCARDIAL FAILURE</b>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>AMYLOIDOSIS OF HEART, KIDNEYS, Liver, Spleen, Adrenals and Tongus</b>	
	DUE TO (c) <b>PLASMA CELL MYELOMA</b>	

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
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19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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. **VA** attended the deceased from **September 26, 1961 to October 20, 1961**  
Death occurred at **k 1:15 A** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <i>S. H. Gray</i>	(Degree or title)	22b. ADDRESS <b>VA Hospital, Kansas City, Mo.</b>	22c. DATE SIGNED <b>10-21-61</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>10 21/61</b>	23c. NAME OF CEMETERY OR CREMATORY <b>National Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Fort Leavenworth, Kansas</b>
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24. FUNERAL DIRECTOR <b>Mrs. Meek's Mortuary</b>	ADDRESS <b>K. C. Mo.</b>	25. DATE RECD. BY LOCAL REG. <b>10-21-61</b>	26. REGISTRAR'S SIGNATURE <i>Ruth Long</i>
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(Licensed Embalmer's Statement on Reverse Side)

DATE AMENDED  
INSTEAD OF  
DOCUMENT  
MEDICAL CERTIFICATION  
BY AFFIDAVIT OF  
ITEM NO. SHOULD READ  
S. H. Gray

**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 William B. Paster

Licensed Embalmer No. 5013  
P. O. Address N. C. 710

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.