SSOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

RTMENT OF PUBLIC HEALTH AND WELFARE

AMENDED

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4920 -61-037065 STATE FILE NUMBER

FILED OCT 1 9 1961

1. PLACE OF DEATH
a. COUNTY JACKSON
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN KANSAS CITY — Length of stay in 1b: 4 days
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION V A HOSPITAL — 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 INDEPENDENCE, — Inside Limits Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location) 1401 ASH — Reside on Farm Yes ☐ No ☒

3. NAME OF DECEASED (Type or print) First: LON Middle: CHARLES Last: MC KENZIE

4. DATE OF DEATH Month: October Day: 3 Year: 1961

5. SEX: Male
6. COLOR OR RACE: White
7. Married ☐ Never Married ☐ Widowed ☒ Divorced ☐
8. DATE OF BIRTH: May 5, 1892
9. AGE (last birthday): 69
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): Fireman, retired
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (City and state or country): Sweet Springs, Mo.
12. CITIZEN OF WHAT COUNTRY: U.S.A.

13a. FATHER'S NAME: James McKenzie
13b. MOTHER'S MAIDEN NAME: Sallie M. Carr
14. NAME OF HUSBAND OR WIFE: ---

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): WWI
16. SOCIAL SECURITY NO.:
17. INFORMANT: VA Hospital Official Records, K.C. Mo. 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) Mucopurulent bronchitis
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Aortic and mitral valvular stenosis
DUE TO (c) Rheumatic heart disease, inactive
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 September 30, 1961 to October 3, 1961
Death occurred at 7:43 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) S. H. CHOY, M.D. — S H Choy
22b. ADDRESS VA Hospital, Kansas City, Mo.
22c. DATE SIGNED 10-4-61

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: Oct. 6, 1961
23c. NAME OF CEMETERY OR CREMATORY: Mt. Washington
23d. LOCATION (City, town, or county) (State): Indep. Mo/

24. FUNERAL DIRECTOR: OTT & MITCHELL ADDRESS: INDEP, MO.
25. DATE RECD. BY LOCAL REG.: 10-4-61
26. REGISTRAR'S SIGNATURE: Ruth Long

(Licensed Embalmer's Statement on Reverse Side)

DATE AMENDED — INSTEAD OF — SHOULD READ — ITEM NO. — DOCUMENT — 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 me,

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____
Signature of Student Embalmer

Signed Henry D. Mitchell

Licensed Embalmer No. 3925

P. O. Address Lindenwood 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.