

SOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

61-041191
5622 STATE FILE NUMBER

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

AMENDED

FILED DEC 1 1961

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Iowa b. COUNTY POLK				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City		Length of stay in 1b 9 days	c. CITY OR TOWN Des Moines Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION VA Hospital		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 3823 West 9th Street Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ALEX Middle NAPIER Last NAPIER			4. DATE OF DEATH Month November Day 3 Year 1961			
5. SEX Male	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 6-14-94	9. AGE (last birthday) 67 yrs	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) Retired		10b. KIND OF BUSINESS OR INDUSTRY --	11. BIRTHPLACE (City and state or country) Chicago, Illinois		12. CITIZEN OF WHAT COUNTRY USA	
13a. FATHER'S NAME --		13b. MOTHER'S MAIDEN NAME --		14. NAME OF HUSBAND OR WIFE --		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW I		16. SOCIAL SECURITY NO. WW I	17. INFORMANT John Lund, Des Moines, Iowa VA Hospital Official Records			
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) Cardiac arrest.						
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.) DUE TO (b) Advanced coronary atherosclerosis.						
DUE TO (c) _____						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Extensive old infarction of left ventricle.				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 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. <input checked="" type="checkbox"/> attended the deceased from October 25, 1961 to November 3-61 Death occurred at 3:45 P m on the date stated above, and to the best of my knowledge, from the causes stated.						
22a. SIGNATURE T.F. Fritzlen		(Degree or title) M.D. T. Fritzlen MD	22b. ADDRESS VA Hospital, Kansas City, Mo.		22c. DATE SIGNED 11-3-61	
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL	23b. DATE NOV. 9, 1961	23c. NAME OF CEMETERY NATIONAL CEMETERY	23d. LOCATION (City, town, or county) (State) FORT LEAVENWORTH KANSAS			
24. FUNERAL DIRECTOR D.W. NEWCOMER'S SONS KANSAS CITY, MO.		ADDRESS 1331 BRUSH CR.	25. DATE RECD. BY LOCAL REG. 11-9-61	26. REGISTRAR'S SIGNATURE <i>Ruth Long</i>		

DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

SHOULD READ

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

Embalmer Michael

Licensed Embalmer No. 4340

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.