

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=62-001656

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 420

STATE FILE NUMBER

AMENDED

FILED FEB 13 1962

1. PLACE OF DEATH a. COUNTY <b>JACKSON</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>KANSAS</b> b. COUNTY <b>Miami</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>KANSAS CITY</b>		Length of stay in 1b <b>32 days</b>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>VA HOSPITAL</b>		c. CITY OR TOWN <b>PAOLA</b>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS <b>Rual Route</b>	
		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last <b>ALBERT G. FLAKE</b>			4. DATE OF DEATH Month Day Year <b>JANUARY 23, 1962</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>5-16-94</b>	9. AGE (last birthday) <b>67</b>	IF UNDER 1 YEAR Months Days	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>Retired</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Tavern</b>	11. BIRTHPLACE (City and state or country) <b>Paola, Kansas</b>	12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>
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13a. FATHER'S NAME <b>John L. Flake</b>	13b. MOTHER'S MAIDEN NAME <b>Minnie Debrick</b>	14. NAME OF HUSBAND OR WIFE <b>Hallie Flake</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) <b>Yes WWI</b>	16. SOCIAL SECURITY NO.	17. INFORMANT Address <b>VA HOSPITAL OFFICIAL RECORDS, K. C. MO.</b>
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18. CAUSE OF DEATH (Enter only one cause per line for PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CIRRHOSIS</b>		INTERVAL BETWEEN ONSET AND DEATH
DUE TO (b) <b>HEPATIC COMA</b>		
DUE TO (c) <b>ESOPHAGEAL VARICES</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.  
 Yes  No  Unknown

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 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. VA attended the deceased from <b>12-22-61</b> to <b>1-23-62</b> and last saw her <b>1/23/62</b> Death occurred at <b>9:15 p.</b> on the date stated above, and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE <b>Don Spencer</b> (Degree or title) <b>M.D.</b>	22b. ADDRESS <b>VA Hospital, K. C. Mo.</b>	22c. DATE SIGNED <b>1-23-62</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>Jan. 24, 1962</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Walnut Creek Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Paola Kansas</b>
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24. FUNERAL DIRECTOR <b>D.W. Newcomer's Sons, Kansas City, Mo</b>	25. DATE RECD. BY LOCAL REG. <b>1-24-62</b>	26. REGISTRAR'S SIGNATURE <b>Ruth Long</b>
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AMENDMENTS ON THIS RECORD ARE AS FOLLOWS  
 INSTEAD OF  
 DOCUMENT  
 MEDICAL CERTIFICATION  
 BY AFFIDAVIT OF  
 Don Spencer  
 ITEM NO. SHOULD READ

VS FEB 14 1962

**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 Levitt, Michael

Licensed Embalmer No. 4340

P. O. Address Kansas City, 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. \_ \_