

# JURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

= 62-006506  
STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 967

**FILED MAR 7 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>SEDGEWICK</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>KANSAS CITY</b>		Length of stay in 1b <b>39 days</b>	c. CITY OR TOWN <b>WICHITA</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>VA Hospital, K.C., Mo.</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>1554 Fairmount</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last <b>ROBERT BENNET GILKISON</b>			4. DATE OF DEATH Month Day Year <b>FEBRUARY 17, 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>7-28-98</b>	9. AGE (last birthday) <b>63</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>FARM PLACEMENT SUPERVISOR</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>K. STATE EMPLOYMENT SERV.</b>		11. BIRTHPLACE (City and state or country) <b>LINCOLN CO, KANSAS</b>	12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>
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13a. FATHER'S NAME <b>BOYD F. Gilkison</b>		13b. MOTHER'S MAIDEN NAME <b>JOSET WEBB</b>		14. NAME OF HUSBAND OR WIFE <b>LOUELLA</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 WW I</b>		16. SOCIAL SECURITY NO. <b>---</b>	17. INFORMANT <b>Official Records VA Hospital, 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
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IMMEDIATE CAUSE (a) **Cerebral edema**

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b) **Postoperative state, 7 hours, suboccipital craniotomy with removal of hemangioblastoma of left cerebellar hemisphere**

DUE TO (c) **hemisphere**

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Coronary atherosclerosis</b>			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.)			
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20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.					
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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. attended the deceased from <b>Jan 9, 1962</b> to <b>Feb 17, 1962</b>				
Death occurred at <b>5:30 A.M.</b> on the date stated above, and to the best of my knowledge, from the causes stated.				

22a. SIGNATURE (Degree or title) <b>T. J. FRITZLAN, M.D. T J Fritzlan MD</b>		22b. ADDRESS <b>V.A. HOSPITAL, K.C., MO.</b>	22c. DATE SIGNED <b>2-17-62</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>Feb. 18-1962</b>	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or county) (State) <b>Hope 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>2-18-62</b>	26. REGISTRAR'S SIGNATURE <b>Ruth Long</b>
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ITEM NO. SHOULD READ BY AFFIDAVIT OF MEDICAL CERTIFICATION DOCUMENT INSTEAD OF

AUG 28 1963

MAR 20 1962

MAY 10 1962

MAY 17 1962

AUG 28 1963

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 Harold D. Quirk

Licensed Embalmer No. 4998

P. O. Address R.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.