

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-019385  
STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 166 Primary Registration District No. 5605 Registrar's No. 13

FILED MAY 21 1962

VS 300  
Rev. 4/59

7510  
28120

3  
4 0  
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7 1  
8 1  
99168  
10 10  
11 0.51  
123-0  
133-0

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <b>Johnson</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Illinois</b> b. COUNTY <b>Cook</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Washington</b> <i>Jur.</i>		Length of stay in lb <b>8 months</b>	c. CITY OR TOWN <b>Chicago</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>USAF Hospital Whiteman AFB Mo</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>5830 South Tripp</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Jacob</b> Middle <b>-</b> Last <b>Lang</b>			4. DATE OF DEATH Month <b>May</b> Day <b>15</b> Year <b>1962</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>20 Dec 43</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Military</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>USAF</b>	9. AGE (last birthday) <b>18</b> IF UNDER 1 YEAR Months Days Hours Min.
11. BIRTHPLACE (City and state or country) <b>Chicago, Illinois</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.</b>	
13a. FATHER'S NAME <b>Jacob Lang</b>		13b. MOTHER'S MAIDEN NAME <b>Laura Talarski</b>	
14. NAME OF HUSBAND OR WIFE <b>-</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes, give war or dates of service) <b>Present</b>	
16. SOCIAL SECURITY NO. <b>[REDACTED]</b>		17. INFORMANT Address <b>Military Records, Whiteman AFB, Missouri</b>	
18. CAUSE OF DEATH (Enter only one cause per line for PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute pulmonary edema and asphyxiation</b> DUE TO (b) <b>Inhalation of heat, smoke and fumes due to fire</b> DUE TO (c) <b>With extensive burns of head, trunk and extremities.</b>			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. <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 checked="" 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.) <b>Explosion of aircraft fuel tanks</b>	
20c. TIME OF INJURY <b>1600</b> Hour a.m. p.m.	Month, Day, Year <b>May 15 62</b>		
20d. INJURY OCCURRED WHILE AT WORK <input checked="" 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.) <b>Flight-line</b>	20f. CITY, TOWN, OR LOCATION <b>Whiteman AFB, Missouri</b>	COUNTY STATE
21. I attended the deceased from _____, to _____ and last saw her/him alive on _____ Death occurred at _____ on the date stated above, and to the best of my knowledge, from the causes stated. <b>Joseph D McGeary</b> (Signature) <b>JOSEPH D MC GEARY LT COL MD</b> (Name and title)			
22b. ADDRESS <b>USAF Hospital Whiteman AFB, Missouri</b>		22c. DATE SIGNED <b>16 May 62</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial Removal</b>	23b. DATE <b>5/17/62</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Chicago, Ill.</b>	23d. LOCATION (City, town, or county) <b>Chicago, Ill.</b>
24. FUNERAL DIRECTOR <b>Sweeney-Phillips, Warrensburg, Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>May 16-62</b>	26. REGISTRAR'S SIGNATURE <b>Erma L. Beatty</b>

1. Name of Deceased \_\_\_\_\_  
2. Address of Deceased \_\_\_\_\_  
3. City and State of Deceased \_\_\_\_\_

4. Date of Death \_\_\_\_\_  
5. Cause of Death \_\_\_\_\_  
6. Place of Death \_\_\_\_\_  
7. Name of Physician \_\_\_\_\_  
8. Name of Hospital \_\_\_\_\_  
9. Name of Funeral Home \_\_\_\_\_

**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 J. Earl Rust  
\_\_\_\_\_

Licensed Embalmer No. 3878

P. O. Address Warrensburg 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.