

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH
DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-031033
4194 STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4194

FILED AUG 28 1962

VS 300
Rev. 4/59

DATE AMENDED

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AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY JACKSON		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE KANSAS b. COUNTY JOHNSON	
b. CITY (If outside corporate limits, give TOWNSHIP only) KANSAS CITY		Length of stay in lb 4 months	c. CITY OR TOWN WESTWOOD
c. FULL NAME OF (If NOT in hospital, give location) V A HOSPITAL		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 4903 BELINDER ROAD
3. NAME OF DECEASED (Type or print) First Middle Last WILLIAM S. HASWELL		4. DATE OF DEATH Month Day Year August 13, 1962	
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 11-1-91
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk, retired		10b. KIND OF BUSINESS OR INDUSTRY Office & Credit Mgr.	9. AGE (last birthday) 70
13a. FATHER'S NAME Frank Haswell		13b. MOTHER'S MAIDEN NAME Minnie Shall	12. CITIZEN OF WHAT COUNTRY U.S.A.
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WWI		17. INFORMANT VA Hospital Official Records, K.C. Mo.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple Nephritic abscesses and acute pyelonephritis, rt. DUE TO (b) Congenital atresia of left kidney DUE TO (c) Prostatic hypertrophy and hydroureter. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		INTERVAL BETWEEN ONSET AND DEATH	
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. VA attended the deceased from April 18, 1962 to August 13, 1962		Death occurred at 1:00 Pm on the date stated above, and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE (Type or Print) STEPHEN PARKS, M.D.		22b. ADDRESS VA Hospital, Kansas City, Mo.	22c. DATE SIGNED 8-13-62
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	23b. DATE 8-15-62	23c. NAME OF CEMETERY OR CREMATORY Elmwood Crematory	23d. LOCATION (City, town, or county) (State) Kansas City, Mo.
24. FUNERAL DIRECTOR ADDRESS Freeman Mortuary Kansas City, Mo.		25. DATE RECD. BY LOCAL REG. 8-14-62	26. REGISTRAR'S SIGNATURE <i>Ruth Long</i>

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 Clayton K. Barnes

Licensed Embalmer No. 4793

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.