

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-036250

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 5177 STATE FILE NUMBER

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Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

| | | | |
|--|---|---|---|
| 1. PLACE OF DEATH a. COUNTY JACKSON | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY Lafayette | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN KANSAS CITY, MISSOURI | | Length of stay in 1b 5 days | c. CITY OR TOWN CONCORDIA, MO. 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, KC, MO. | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First ARTHUR Middle D Last KAISER | | | 4. DATE OF DEATH Month SEPTEMBER Day 22 Year 1963 |
| 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 2/27/96 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FILLING STATION OPERATOR | | 10b. KIND OF BUSINESS OR INDUSTRY FILLING STATION | 9. AGE (last birthday) 67 IF UNDER 1 YEAR: Months <input type="checkbox"/> Days <input type="checkbox"/> IF UNDER 24 HR: Hours <input type="checkbox"/> Min. <input type="checkbox"/> |
| 11a. FATHER'S NAME GUS KAISER | | 11b. MOTHER'S MAIDEN NAME MARGARET KERR | 11. BIRTHPLACE (City and state or country) ALMA, MO. |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) YES 7/7/18 to 7/28/1 | | 12. CITIZEN OF WHAT COUNTRY U.S.A. | |
| 16. SOCIAL SECURITY NO. | | 14. NAME OF HUSBAND OR WIFE NEVER MARRIED | |
| 18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE PASSIVE CONGESTION AND EDEMA OF THE LUNGS DUE TO (b) POST OPERATIVE STATUS: VAGOTOMY AND ANTRECTOMY DUE TO (c) BLEEDING DUODENAL ULCER (OPERATIVE FINDING) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) | | 17. INFORMANT Address ALMA, MO. VA HOSPITAL RECORDS/SAM KAISER (Nephew) INTERVAL BETWEEN ONSET AND DEATH | |
| 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.) | |
| 20c. TIME OF INJURY Hour <input type="checkbox"/> a.m. <input type="checkbox"/> p.m. | 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" 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 9/17/63 to 9/22/63 and last saw him alive on 9/22/63 Death occurred at 1:40 AM 9/22/63 m on the date stated above, and to the best of my knowledge, from the causes stated. | | | |
| 22a. SIGNATURE Robert L. Lovelace (Type or print) | | 22b. ADDRESS VA HOSPITAL, KANSAS CITY, MO | 22c. DATE SIGNED 9-22-63 |
| 23a. BURIAL, CREMATION, REINTERMENT (Specify) | 23b. DATE Sept 24-63 | 23c. NAME OF CEMETERY OR CREMATOR Three Grove | 23d. LOCATION (City, town, or county) Alma Mo. |
| 24. FUNERAL DIRECTOR Wiesner-Rueckhoff Higginson | | 25. DATE RECD. BY LOCAL REG. 9-23-63 | 26. REGISTRAR'S SIGNATURE Bessie Smith |

USE BLACK INK OR TYPEWRITER RIBBON

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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 Donald R. Wiggins

Licensed Embalmer No. 5712

P. O. Address Higginsville 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.