

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-039825

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

DO NOT WRITE ON THIS STUB AMENDED

VS 300	DATE AMENDED
Rev. 4/59	
1	
2 <i>8/50</i>	
3	
4 <i>0</i>	
5 <i>1</i>	
6	
7 <i>1</i>	
8 <i>1</i>	
9 <i>1/621</i>	
10	
11	
12 <i>64-0</i>	
13	

USE BLACK INK OR TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

BY AFFIDAVIT OF **Frank B. Leitz** MEDICAL CERTIFICATION

Registration District No. <u>149</u> Primary Registration District No. <u>1002</u> Registrar's No. <u>5503</u>		STATE FILE NUMBER	
File <u>OCT 24 1963</u>			
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) OR TOWN Kansas City		Length of stay in 1b 2 weeks	c. CITY OR TOWN Lenexa Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Research Hospital		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 7600 Lackmen Rd. Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First ROBERT Middle EMMETT Last CASH, Jr.			4. DATE OF DEATH Month Oct. Day 11, Year 1963
5. SEX M	6. COLOR OR RACE W	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 7-18-1920
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer		10b. KIND OF BUSINESS OR INDUSTRY Railroad	9. AGE (last birthday) 43 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 Robert E. Cash, Sr.		11b. MOTHER'S MAIDEN NAME Emma Lamp	12. CITIZEN OF WHAT COUNTRY USA
13a. FATHER'S NAME		14. NAME OF HUSBAND OR WIFE Flossie M. Cash	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. <input type="checkbox"/>	17. INFORMANT Address Mrs. Flossie M. Cash Lenexa, Ks.
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchogenic Carcinoma DUE TO (b) Congestive Heart Failure DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH 10 mo 4 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Anemia from Coarctation.			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 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, store, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE
21. I attended the deceased from April 1963 to Oct 11-63 and last saw him alive on Oct 11 1963 Death occurred at 9:40am m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Frank B. Leitz MD		22b. ADDRESS Prof. Bldg. KC, Mo.	22c. DATE SIGNED 10-11-63
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 10-11-63	23c. NAME OF CEMETERY OR CREMATORY Maple Hill Cemetery	23d. LOCATION (City, town, or county) (State) Kansas City, Kansas
24. FUNERAL DIRECTOR ADDRESS Eugene P. Amos Shawnee, Kansas		25. DATE RECD. BY LOCAL REG. 10-11-63	26. REGISTRAR'S SIGNATURE Bessie Smith

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

Eugene P. Amos
Eugene P. Amos

Licensed Embalmer No. 5023

P. O. Address Shawnee, Kansas

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.