

**THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH**

8964

State File No.

909

BIRTH NO. **FILED MAR 18 1954** REG. DIST. NO. **149** PRIMARY REG. DIST. NO. **1002** Registrar's No.

1. PLACE OF DEATH a. COUNTY JACKSON		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE KANSAS b. COUNTY WYANDOTTE	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN KANSAS CITY		c. CITY OR TOWN KANSAS CITY	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>
c. LENGTH OF STAY (in this place) 23 mo.		* STREET ADDRESS (If rural, give location) 515 Minnesota	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION VETERANS ADMINISTRATION HOSPITAL			

3. NAME OF DECEASED (Type or Print) a. (First) ROSS b. (Middle) A. c. (Last) TEASLEY		4. DATE OF DEATH (Month) (Day) (Year) February 25, 1954	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Divorced	8. DATE OF BIRTH March 4, 1901
9. AGE (In years last birthday) 52		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Barber	10b. KIND OF BUSINESS OR INDUSTRY Barber
11. BIRTHPLACE (City and State or Foreign Country) Geary, Oklahoma		12. CITIZEN OF WHAT COUNTRY? USA	

13a. FATHER'S NAME John W. Teasley	13b. MOTHER'S MAIDEN NAME Lucille Smile	14. NAME OF HUSBAND OR WIFE -----
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes	16. SOCIAL SECURITY NO. 511-10-4025	17. INFORMANT'S SIGNATURE OR NAME VA Hospital Official Records, Kansas City	ADDRESS
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pulmonary edema		INTERVAL BETWEEN ONSET AND DEATH 2 days
	ANTECEDENT CAUSES DUE TO (b) Diabetic nephropathy		1 1/2 years
	DUE TO (c) Diabetes Mellitus		16 years
	II. OTHER SIGNIFICANT CONDITIONS Generalized arteriosclerosis Arteriosclerotic heart disease		10 years

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) VA m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from Dec. 8, 1953, to February 25, 1954, and that death occurred at 11:40 P.M.; from the causes and on the date stated above.

23a. SIGNATURE THOMAS J. RANKIN, M.D.	(Degree or title) D.	23b. ADDRESS VA Hospital, Kansas City, Mo.	23c. DATE SIGNED 2/26/54
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24a. BURIAL, CREMATION, REMOVAL Removal	24b. DATE 2-26-54	24c. NAME OF CEMETERY OR CREMATORY Natoma, Kansas	24d. LOCATION (City, town, or county) (State) Natoma, Kansas
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DATE REC'D BY LOCAL REG. 2-27-54	REGISTRAR'S SIGNATURE Seraldine Smith	25. FUNERAL DIRECTOR'S SIGNATURE Ralph A. Fulton, Kansas City, Kansas	ADDRESS
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(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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 *Ralph Fulton*

Licensed Embalmer No. *35*

P. O. Address *Y. C. K.*

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.