

FILED JUL 12 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **19161**
2654

BIRTH NO. _____ 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 **JOHNSON**

b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN **KANSAS CITY**
c. LENGTH OF STAY (in this place) **1 mo. 4 days**
4 years

c. CITY OR TOWN **MISSION**
d. Is Residence within limits of a city or incorporated town? Yes No

d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION **VETERANS ADMINISTRATION HOSPITAL**
e. STREET ADDRESS (If rural, give location) **4630 W. 61st Terrace** **8150**

3. NAME OF DECEASED
a. (First) **FRANK** b. (Middle) **P.** c. (Last) **SHOFSTALL**

4. DATE OF DEATH (Month) (Day) (Year) **June 10, 1954**

5. SEX **0** Male
6. COLOR OR RACE **White**

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) **Married**

8. DATE OF BIRTH **July 3, 1896**

9. AGE (In years) (last birthday) **57**
IF UNDER 1 YEAR: Months _____ Days _____
IF UNDER 10 HRS. Hours _____ Min. _____

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **Manager**

10b. KIND OF BUSINESS OR INDUSTRY **C. Terminal P.R.**

11. BIRTHPLACE (City and State or Foreign Country) **Paola, Kansas**

12. CITIZEN OF WHAT COUNTRY? **U.S.A.**

13a. FATHER'S NAME **William M. Shofstall**

13b. MOTHER'S MAIDEN NAME **Anna B. Howland**

14. NAME OF HUSBAND OR WIFE **Vivian SHOFSTALL**

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) **Yes WBI**

16. SOCIAL SECURITY NO. **321-09-9622**

17. INFORMANT'S SIGNATURE OR NAME **VA Hospital Official Records** ADDRESS **Kansas City Mo**

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, ashenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) **Purulent tracheobronchitis with obstructive emphysema**
ANTECEDENT CAUSES **Chronic retroperitoneal phlegmon**
DUE TO (b) **Hematomyelia** (HISTORY OF PYLEONEPHRITIS KIDNEY REMOVED)
DUE TO (c) **Anaplastic Sarcoma of soft parts involving thorax and back**
II. OTHER SIGNIFICANT CONDITIONS **thorax and back**
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH
2 days
2 years
1 week
2 weeks

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION **600**

20. AUTOPSY? YES NO

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)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) **VA**

21e. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **May 6, 1954** to **June 10, 1954**, and that death occurred at **1:55 P.M.**, from the causes and on the date stated above.

23a. SIGNATURE **Frank A. Mantz Jr. M.D.** (Degree or title) **0**

23b. ADDRESS **VA Hospital, Kansas City, Mo**

23c. DATE SIGNED **6/11/54**

24a. BURIAL, CREMATION, REMOVAL (Specify) **BURIAL**

24b. DATE **JUNE 12 1954**

24c. NAME OF CEMETERY OR CREMATORY **MT. MORIAN CEMETERY**

24d. LOCATION (City, town, or county) (State) **KANSAS CITY MISSOURI**

DATE REC'D BY LOCAL REG. **6-12-54**

REGISTRAR'S SIGNATURE **Seraldine Smith**

25. FUNERAL DIRECTOR'S SIGNATURE **D.H. Newcomer's Sons** ADDRESS **1331 BRUSH CREEK KANSAS CITY MO**

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was by me, or by Student Embalmer No. working under my personal supervision..

Student Signature of Student Embalmer

Signed *Robert Ray*

Licensed Embalmer No. *4*

P. O. Address *Kans.*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING 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.