

FILED JUL 8 - 1955

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **19015**  
**2658**

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. 2658

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY <b>Jackson</b>	
b. CITY OR TOWN <b>Kansas City</b> <small>(If outside corporate limits, write RURAL and give township)</small>		c. CITY OR TOWN <b>Kansas City</b> <small>(in this place)</small>	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) <b>20 yrs. 10 days</b>		STREET ADDRESS (If rural, give location) <b>3118 0 1111 Park Ave</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Queen of The World Hsp'tal</b>			

3. NAME OF DECEASED (Type or Print) a. (First) <b>Jesse</b>	b. (Middle) <b>Franklin</b>	c. (Last) <b>VanWinkle</b>	4. DATE OF DEATH (Month) (Day) (Year) <b>June 20-55</b>
----------------------------------------------------------------	-----------------------------	----------------------------	------------------------------------------------------------

5. SEX <b>Male</b>	6. COLOR OR RACE <b>Col.</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>Oct-30-1882</b>	9. AGE (In years last birthday) <b>72</b>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 2 HRS. Hours _____ Min. _____
--------------------	------------------------------	-----------------------------------------------------------------------	-------------------------------------	-------------------------------------------	-----------------------------------------	----------------------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unemployed</b>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) <b>Neosho, Mo</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
---------------------------------------------------------------------------------------------------------------	-----------------------------------	----------------------------------------------------------------------	--------------------------------------------

13a. FATHER'S NAME <b>Henry Van Winkle</b>	13b. MOTHER'S MAIDEN NAME <b>Mary Bullard</b>	14. NAME OF HUSBAND OR WIFE <b>Florence Eugenia VanWinkle</b>
--------------------------------------------	-----------------------------------------------	---------------------------------------------------------------

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	16. SOCIAL SECURITY No. <b>487-05-5304</b>	17. INFORMANT'S SIGNATURE OR NAME <b>Florence B. VanWinkle</b>	ADDRESS <b>1111 Park</b>
-----------------------------------------------------------------------------	--------------------------------------------	----------------------------------------------------------------	--------------------------

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, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a) <b>Pulmonary Artery thrombosis</b>		<b>30 min</b>
	ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>A-S Cardiovascular dis</b>		<b>3 yrs.</b>
DUE TO (c)		<b>610X</b>	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>Prostatic Hemorrhage before admission operation</b>		<b>1 day</b>	

19a. DATE OF OPERATION <b>6-10-55</b>	19b. MAJOR FINDINGS OF OPERATION <b>Enlarged Benign Prostate</b>	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
---------------------------------------	------------------------------------------------------------------	----------------------------------------------------------------------------------

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)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
-------------------------------------------------	--------------------------------------------------------------------------------------------------------	----------------------------

22. I hereby certify that I attended the deceased from 5-30, 1955, to 6-20, 1955, that I last saw the deceased alive on 6-19, 1955, and that death occurred at 8 A m., from the causes and on the date stated above.

23a. SIGNATURE <b>Wm. A. Staggs</b> (Degree or title)	23b. ADDRESS <b>M. 12 1030 Apple, K.C., Mo.</b>	23c. DATE SIGNED <b>6-20-55</b>
-------------------------------------------------------	-------------------------------------------------	---------------------------------

24a. PORTAL CREMATION REMOVAL (Specify) <b>Burial</b>	24b. DATE <b>June 24-55</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Westlawn Cemetery</b>	24d. LOCATION (City, town, or county) (State) <b>K.C. KANS</b>
-------------------------------------------------------	-----------------------------	-------------------------------------------------------------	----------------------------------------------------------------

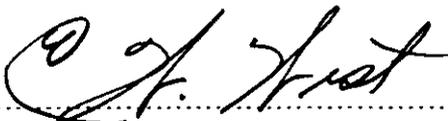
DATE REC'D BY LOCAL REG <b>6-21-55</b>	REGISTRAR'S SIGNATURE <b>Neve Marshall</b>	FUNERAL DIRECTOR'S SIGNATURE <b>Marlene Williams</b>	ADDRESS <b>1729 Leche</b>
----------------------------------------	--------------------------------------------	------------------------------------------------------	---------------------------

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.....  


Licensed Embalmer No. 2710

P. O. Address K. C.

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.