

Health,
Welfare
Public
Service

300
1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
Lew W. Purinton

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED MAY 20 1957

17339

STATE FILE NUMBER
2048

Registration District No. 149 Primary Registration District 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, give TOWNSHIP only) OR TOWN KANSAS CITY		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN KANSAS CITY		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION V.A. HOSPITAL		Length of stay in lb 107 days	d. STREET ADDRESS (If outside, give location) 217 Orchard		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First AMI Middle A. Last SCHILL			4. DATE OF DEATH Month 4th Day 28th Year 1957		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-26-09	9. AGE (In years last birthday) 48 yrs	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Postal Clerk		10b. KIND OF BUSINESS OR INDUSTRY Postal	11. BIRTHPLACE (City and state or country) Kansas City, Kansas		12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME Frank Schill			14. MOTHER'S MAIDEN NAME Bell Schill Morgan		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WWII		16. SOCIAL SECURITY NO. 545-36-7219	17. INFORMANT Address Hazel Schill, K.C. Kansas V.A. Hospital Records, K.C., Mo.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic carcinoma of the brain Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Carcinoma of lung, Primary DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					INTERVAL BETWEEN ONSET AND DEATH 5 mos 7 mos 16 1/2
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 Month, Day, Year a. m. p. m.					
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, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from January 7 1957 to April 28, 1957 Death occurred at 11:50 p m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) Lew W. Purinton MD			22b. ADDRESS V.A. Hospital, Kansas City, Mo		22c. DATE SIGNED 4-29-57
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE May 1, 1957	23c. NAME OF CEMETERY OR CREMATORY National Cemetery		23d. LOCATION (City, town, or county) (State) Fort Scott, Kansas
24. FUNERAL DIRECTOR Jos. A. Butler's Sons,		ADDRESS K.C., Mo.		25. DATE RECD. BY LOCAL REG. 4-30-57	26. REGISTRAR'S SIGNATURE Hazel Marshall



Handwritten vertical text, possibly a name or date.

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 O. Groll*

Licensed Embalmer No. 500

P. O. Address K. C. Ka

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