

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

24396

STATE FILE NUMBER

FILED AUG 1 - 1957

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 3142

Use only black ink or ribbon typewrite if possible. Coroner cannot certify to a death due to natural causes. Diseases in Part I must be causally related.

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 (If outside corporate limits, give TOWNSHIP only) <b>KANSAS CITY</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <b>KANSAS CITY</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) <b>VETS. ADM. HOSPITAL</b>			Length of stay <b>10 DAYS</b>	STREET ADDRESS (If outside, give location) <b>225 NO. WHEELING</b>			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>JOSEPH</b> Middle <b>M.</b> Last <b>BARTHELETTE</b>				4. DATE OF DEATH Month <b>July</b> Day <b>3</b> Year <b>1957</b>				
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>July 14, 1895</b>		9. AGE (In years and birthday) <b>61</b>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>U. S. Navy Personnel, retired</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <b>Loyden, No. Dakota</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Unknown</b>				14. MOTHER'S MAIDEN NAME <b>BARTHELETTE</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes World War I</b>		16. SOCIAL SECURITY NO. <b>553-10-0425</b>		17. INFORMANT Address <b>Official VA Hospital Records, K. C. Mo.</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u>  Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Severe pulmonary congestion with edema</u> DUE TO (c) <u>Carcinoma of stomach with extensive metastasis.</u> 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	
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, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION		COUNTY STATE		
21. attended the deceased from <u>April 1, 1957</u> to <u>July 3, 1957</u> <del>XXXXXXXXXX</del> Death occurred at <u>8:27 P. M.</u> on the date stated above; and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE <u>A. J. Williams</u> (Degree or title) <b>M.D.</b>				22b. ADDRESS <b>VA Hospital 4801 Linwood, Kansas City, Mo.</b>		22c. DATE SIGNED <b>7-5-57</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)			
<b>BURIAL</b>		<b>JULY 9 1957</b>	<b>MT. CALVARY CEMETERY</b>		<b>KANSAS CITY KANSAS</b>			
24. FUNERAL DIRECTOR ADDRESS			25. DATE RECD. BY LOCAL REG.		26. REGISTRAR'S SIGNATURE			
<b>D. W. NEWCOMER'S SONS, KANSAS CITY, MO.</b>			<b>7-8-57</b>		<b>Robt Minshall</b>			

STATE OF MISSISSIPPI  
 DEPARTMENT OF HEALTH  
 BUREAU OF PUBLIC HEALTH  
 MEMPHIS, TENNESSEE  
 MISSISSIPPI DEPARTMENT OF HEALTH  
 BUREAU OF PUBLIC HEALTH  
 MEMPHIS, TENNESSEE  
 STATE OF MISSISSIPPI  
 DEPARTMENT OF HEALTH  
 BUREAU OF PUBLIC HEALTH  
 MEMPHIS, TENNESSEE

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 *Basil V. Honey*.....  
 Licensed Embalmer No. *44*

P. O. Address *K.P.*

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.