

FILED APR 22 1958

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-014442

STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 1649

5. 300
1-57

1. PLACE OF DEATH a. COUNTY <u>JACKSON</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>JACKSON</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>KANSAS CITY</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>KANSAS CITY</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>442 WEST 68TH STREET</u>		Length of stay in 1b <u>74 YEARS</u>	d. STREET ADDRESS (If outside, give location) <u>442 WEST 68TH STREET</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>THOMAS D. SAMUEL JR.</u>			4. DATE OF DEATH Month Day Year <u>MARCH 27 1958</u>
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JULY 15 1893</u>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ENGINEER</u>		9b. KIND OF BUSINESS OR INDUSTRY <u>WATER DEPART</u>	9c. AGE (In years last birthday) <u>74</u> IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ENGINEER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>WATER DEPART</u>	11. BIRTHPLACE (City and state or country) <u>KANSAS CITY, MISSOURI</u>
13a. FATHER'S NAME <u>THOMAS D. SAMUEL SR.</u>		13b. MOTHER'S MAIDEN NAME <u>ELIZABETH WALSMITH</u>	14. NAME OF HUSBAND OR WIFE <u>ALMA SAMUEL</u>
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>491-22-3086</u>	17. INFORMANT <u>ALMA SAMUEL-442 WEST 68TH ST. K.C., MO</u> Address
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>Adenocarcinoma of the Bronchus</u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 months</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			<u>162¹</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Arteriosclerotic Heart Disease</u>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <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 <u>Sept 1955</u> to <u>March 27, 58</u> and last saw ^{her} him alive on <u>March 27, 58</u> Death occurred at <u>11:18 A.M.</u> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>Harold W. Voth, M.D.</u> (Degree or title)		22b. ADDRESS <u>201 Plaza Med. Bldg. 315 Nichols Rd. - K.C. MO.</u>	22c. DATE SIGNED <u>Mar. 28, 58</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>MARCH 29, 1958</u>	23c. NAME OF CEMETERY OR CREMATORY <u>FOREST HILL</u>	23d. LOCATION (City, town, or county) (State) <u>KANSAS CITY, MISSOURI</u>
24. FUNERAL DIRECTOR <u>D.W. NEWCOMER'S SONS</u> ADDRESS <u>1331 BRUSH CREEK KANSAS CITY, MO</u>		25. DATE RECD. BY LOCAL REG. <u>3-29-58</u>	26. REGISTRAR'S SIGNATURE <u>Neva Marshall</u>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

1. All diseases in Part I must be causally related.
2. No symptoms will be listed.

Harold W. Voth

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 *Chester K Brown*

Licensed Embalmer No. *4931*

P. O. Address *KE MO*

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.