

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-044462

STATE FILE NUMBER 5797

FILED DEC 30 1958 Registration District No. 149 Primary Registration District No. 1002 Registrar's No.

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) OR <b>Kansas City</b> TOWN		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) HOSPITAL OR INSTITUTION <b>7604 E. 67th.</b>		Length of stay in 1b <b>70 Yrs</b>	d. STREET ADDRESS (If outside, give location) <b>7604 E. 67th.</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>CARL</b> Middle <b>VAN</b> Last <b>VLIET</b>			4. DATE OF DEATH Month <b>12</b> Day <b>8</b> Year <b>1958</b>	
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5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> / DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7 26 1888</b>	9. AGE (In years less than 1 day) <b>70</b>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Lather</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Building</b>	11. BIRTHPLACE (City and state or country) <b>Kansas City, Mo</b>	12. CITIZEN OF WHAT COUNTRY? <b>U., S. A</b>
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13a. FATHER'S NAME <b>Ernest Van Vliet</b>		13b. MOTHER'S MAIDEN NAME <b>Blanche Unknown</b>		14. NAME OF HUSBAND OR WIFE <b>Mrs. Opal VanVliet</b>	
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown) (If yes, give war or states of service) <b>No</b> <input checked="" type="checkbox"/> <input checked="" type="checkbox"/> <input checked="" type="checkbox"/>		16. SOCIAL SECURITY NO. <b>495 09 9292</b>		17. INFORMANT Address <b>Mrs. Opal VanVliet 7604 E. 67th</b>	
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary thrombosis with myocardial infarction</b>			INTERVAL BETWEEN ONSET AND DEATH <b>48 hours</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause lost. } DUE TO (b) _____ DUE TO (c) <b>Arteriosclerotic heart disease</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>High B</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>

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.)		
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____		
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20d. INJURY OCCURRED WHILE AT <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	
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21. I attended the deceased from **20 Sept 57** to **8 Dec 58** and last saw him alive on **12-8-58**  
Death occurred at \_\_\_\_\_ m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <b>Jack M Davis MD</b> (Degree or title)		22b. ADDRESS <b>Raytown Mo</b>		22c. DATE SIGNED <b>8 Dec 58</b>	
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23a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>12-10-1958</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Floral Hills</b>		23d. LOCATION (City, town, or county) (State) <b>Kansas City Missouri</b>	
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24. FUNERAL DIRECTOR ADDRESS <b>Floral Hills Memorial Chapels,</b>		25. DATE RECD. BY LOCAL REG. <b>12-8-58</b>		26. REGISTRAR'S SIGNATURE <b>Irene Minshall</b>	
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Jack M. Davis

All diseases in Part I must be causally related. Secondary, tertiary, etc., diseases only standard nomenclature in terms of "No symptoms" will be listed.

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 *John R. Didmo*

Licensed Embalmer No. *4531*

P. O. Address *Kansas City*

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.

