

Health, Welfare  
Public  
Service

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THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-005969  
STATE FILE NUMBER

777

FILED FEB 27 1959

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 777

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 TOWN <b>KANSAS CITY</b>		c. CITY OR TOWN <b>JACKSON Kansas City</b>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>4039 GARFIELD AVENUE 39 YEARS</b>		d. STREET ADDRESS (If outside, give location) <b>4039 GARFIELD AVENUE</b>	

3. NAME OF DECEASED (Type or print) First Middle Last <b>WALLACE GARLAND WHITELEY</b>			4. DATE OF DEATH Month Day Year <b>FEBRUARY 9, 1959</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>AUGUST 18, 1872</b>	9. AGE (In years last birthday) <b>86</b>	10. UNDER 1 YEAR Months Days Hours Min.	11. UNDER 24 HRS. Hours Min.
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10b. KIND OF BUSINESS OR INDUSTRY <b>MONUMENTAL LIFE INS. CO.</b>	11. BIRTHPLACE (City and state or country) <b>WAYNE COUNTY, IOWA</b>	12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>
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13a. FATHER'S NAME <b>JAMES E. WHITELEY</b>	13b. MOTHER'S MAIDEN NAME <b>MARY ELLEN ELLSWORTH</b>	14. NAME OF WIFE OR WIFE <b>MRS. RILLA M. WHITELEY</b>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>	16. SOCIAL SECURITY NO. <b>495-03-7843</b>	17. INFORMANT <b>MRS. RILLA M. WHITELEY</b> Address: <b>4039 GARFIELD AVE. KANSAS CITY, MO.</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>Cardiac Failure &amp; Thrombosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 hrs</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <b>Carcinoma of Prostate</b>	<b>Undet.</b>	
	DUE TO (c) <b>Generalized Arterio Sclerosis</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>none</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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 Month, Day, Year a.m. p.m.	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 <u>1951</u> to <u>time of death</u> and last saw him alive on <u>2-9-59</u> Death occurred at <u>1:00 P.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE <i>Leo M. Muller</i> (Deputy or time)	22b. ADDRESS <b>4443 Paul Blvd</b>	22c. DATE SIGNED <b>2-9-59</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>	23b. DATE <b>FEBRUARY 10, 1959</b>	23c. NAME OF CEMETERY OR CREMATOR <b>CORYDON CEMETERY</b>	23d. LOCATION (City, town, or county) (State) <b>CORYDON, IOWA</b>
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24. FUNERAL DIRECTOR <b>D. W. NEWCOMER'S SONS KANSAS CITY, MO.</b>	25. DATE RECD. BY LOCAL REG. <b>2-10-59</b>	26. REGISTRAR'S SIGNATURE <i>Leo M. Muller</i>
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MEDICAL CERTIFICATION  
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
All diseases in Part I must be causally related.  
Leo M. Muller



**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 *Herold L. Eckert*

Licensed Embalmer No. 3035  
P. O. Address Ch. A. 210

**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.**