

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-025363

FILED VS JUL 27 1959

STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 3401

INDEXED

1. PLACE OF DEATH a. COUNTY JACKSON		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY JACKSON	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN KANSAS CITY		Length of stay in 1b 10 YRS.	c. CITY OR TOWN KANSAS CITY Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION ST. MARY'S HOSP.		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 401 A SOUTH WHEELING Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last WILLIAM THOMAS POPE	4. DATE OF DEATH Month Day Year JULY 5, 1959
--	---

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 2 1 1890	9. AGE (last birthday) 69 YRS.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.
-----------------------	----------------------------------	---	-------------------------------------	--	---	------------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ROUND HOUSE CLERK K. C. SOUTHERN R. R.	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) CHESTER, ARKANSAS	12. CITIZEN OF WHAT COUNTRY USA
--	-----------------------------------	--	---

13a. FATHER'S NAME JOHN H. POPE	13b. MOTHER'S MAIDEN NAME LULA MANKIN	14. NAME OF HUSBAND OR WIFE CLYDE POPE
---	---	--

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO	16. SOCIAL SECURITY NO. NONE	17. INFORMANT Address MRS. CLYDE POPE 401 A SO. WHEELING
--	--	--

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ruptured Abdominal aortic aneurysm DUE TO (b) Post op. complication - Retroperitoneal abscess and DUE TO (c) Generalized Peritonitis		INTERVAL BETWEEN ONSET AND DEATH 5-22-59 6-29-59
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) —		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

19. WAS AUTOPSY PERFORMED? YES <input checked="" 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.) —
---	---	--

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 checked="" 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 5-22-59 to 7-5-59 and last saw him alive on 7-5-59 Death occurred at 5:20 AM m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Carl D. Emma MD	22b. ADDRESS Argyle Bldg. K.C. Mo	22c. DATE SIGNED 7-6-59
--	---	-----------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL	23b. DATE JULY 6, 1959	23c. NAME OF CEMETERY OR CREMATORY WOODLAWN CEM	23d. LOCATION (City, town, or county) (State) FORT SMITH ARK.
---	----------------------------------	---	---

24. FUNERAL DIRECTOR ADDRESS W.W. Murrison's Son. N.C. Mo.	25. DATE RECD. BY LOCAL REG. 7-11-59	26. REGISTRAR'S SIGNATURE Neva Marshall
--	--	---

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF
Carl D. Emma

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed

L. O. Talson

Licensed Embalmer No. 4421

P. O. Address Kansas

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.