

DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-029398

FILED VS AUG 21 1959

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 3800 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY JACKSON b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN KANSAS CITY Length of stay in 1b. five 11 days c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION V A HOSPITAL Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY Jackson c. CITY OR TOWN Independence Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) 603 EAST TRUMAN ROAD Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First WALTER Middle DANIEL Last WRIGHT			4. DATE OF DEATH Month July Day 30 Year 1959			
5. SEX Male	6. COLOR OR RACE Negro	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>	8. DATE OF BIRTH 1-26-16	9. AGE (last birthday) 43	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/>	IF UNDER 24 HR Hours <input type="checkbox"/> Min. <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) Independence, Missouri		12. CITIZEN OF WHAT COUNTRY U.S.A.
13a. FATHER'S NAME John Rodger Wright			13b. MOTHER'S MAIDEN NAME Ida		14. NAME OF HUSBAND OR WIFE --	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes <input checked="" type="checkbox"/> WWII		16. SOCIAL SECURITY NO. -		17. INFORMANT VA Hospital Official Records, K. C. Mo 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) Uremia DUE TO (b) Chronic nephritis DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last:					INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Probable Carcinoma of rectum Hypertensive cardiovascular disease with acute pulmonary edema					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 type="checkbox"/> NO <input checked="" 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 July 19, 1959 to July 30, 1959 Death occurred at 8:12 a m on the date stated above, and to the best of my knowledge, from the causes stated.						
22a. SIGNATURE (Degree or title) CHARLES E. ANDREWS, M.D.			22b. ADDRESS VA Hospital, Kansas City, Mo.		22c. DATE SIGNED 7-30-59	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 8/5/59	23c. NAME OF CEMETERY OR CREMATORY Ft. Leavenworth, Kans. Leavenworth, Kans		23d. LOCATION (City, town, or county) (State) (State)	
24. FUNERAL DIRECTOR C. E. Davis K.C. Mo.		25. DATE RECD. BY LOCAL REG. 8-5-59		26. REGISTRAR'S SIGNATURE Vera Minshall		

DOCUMENT

BY AFFIDAVIT OF Disposal Home MEDICAL CERTIFICATION

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 *C. C. Davis*

Licensed Embalmer No. 4417

P. O. Address W. C. W.

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.