

FEDERAL BUREAU OF INVESTIGATION - STANDARD CERTIFICATE OF DEATH

FILED VS NOV 3 0 1959 149

59-040378

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. 1002 Registrar's No. 5433

1. PLACE OF DEATH a. COUNTY JACKSON				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE KANSAS b. COUNTY JOHNSON									
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN KANSAS CITY		Length of stay in 1b 1 day		c. CITY OR TOWN OVERLAND PARK		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>							
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION VA Hospital, K.C., Mo			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 7340 Marty		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First Middle Last RALPH REID SIMCOCK				4. DATE OF DEATH Month Day Year NOVEMBER 9, 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 9-12-95		9. AGE (last birthday) 64		IF UNDER 1 YEAR Months Days		IF UNDER 24 HR Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) Council Groves, Kansas		12. CITIZEN OF WHAT COUNTRY U.S.A.					
13a. FATHER'S NAME ALBERT W. SIMCOCK				13b. MOTHER'S MAIDEN NAME MARY REID				14. NAME OF HUSBAND OR WIFE Oletha					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) YES WW I				16. SOCIAL SECURITY NO. 486-01-2016		17. INFORMANT Address Official Records VA Hospital, K.C., Mo.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure										INTERVAL BETWEEN ONSET AND DEATH			
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.										DUE TO (b) _____			
DUE TO (c) _____													
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 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.)					
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 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 November 8, 1959 to November 9, 1959 Death occurred at 8:40 P.M. on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE <i>Thomas R. Hunt</i> THOMAS R. HUNT, M.D.						22b. ADDRESS VA Hospital, K.C., Mo.						22c. DATE SIGNED 11-10-59	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE NOV 12, 1959		23c. NAME OF CEMETERY OR CREMATORY FOREST HILL CEM				23d. LOCATION (City, town, or county) (State) KANSAS CITY, MO.					
24. FUNERAL DIRECTOR D. W. NEWCOMER'S SONS K. C. MO.						25. DATE RECD. BY LOCAL REG. 11-11-59		26. REGISTRAR'S SIGNATURE <i>Reva Merisall</i>					

DOCUMENT

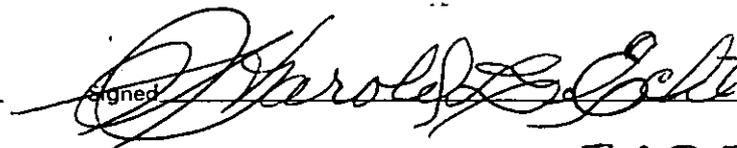
MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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 

Licensed Embalmer No. 3035

P. O. Address H. E. Galt

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.