

U.S. DEPARTMENT OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-040493

FILED NOV 17 1959

149

Primary Registration District No. 1000

Registrar's No.

5303

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <b>JACKSON</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>KANSAS</b> b. COUNTY <b>WYANDOTTE</b>					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>KANSAS CITY</b>		Length of stay in 1b <b>91 Days</b>		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>VA Hospital, K.C., Mo.</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>5912 Metropolitan</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>JOHN</b> Middle <b>YURGLE</b> Last <b>AKA YURGEL</b>				4. DATE OF DEATH Month <b>November</b> Day <b>1</b> Year <b>1959</b>					
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>12-15-93</b>	9. AGE (last birthday) <b>65</b>	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) <b>FOREMAN</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>PACKING HOUSE</b>		11. BIRTHPLACE (City and state or country) <b>RUSSIA</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>		
13a. FATHER'S NAME <b>IGNACY YURGIE</b>			13b. MOTHER'S MAIDEN NAME <b>AGNES BOBOWECH</b>			14. NAME OF HUSBAND OR WIFE <b>AGNES</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>YES WW I</b>			16. SOCIAL SECURITY NO. <b>515 05 2871</b>		17. INFORMANT Address <b>Official Records VA Hospital, K.C., Mo</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:							INTERVAL BETWEEN ONSET AND DEATH		
IMMEDIATE CAUSE (a) <b>Aspirated vomitus</b>									
DUE TO (b) _____									
DUE TO (c) <b>Carcinoma, bronchus, RML</b>									
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 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. Attended the deceased from <b>August 3, 1959</b> to <b>November 1, 1959</b> Death occurred at <b>9:50 P.</b> m on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE <b>J. A. TURNER, M.D.</b> (Deceased or title)				22b. ADDRESS <b>VA Hospital, Kansas City, Mo.</b>				22c. DATE SIGNED <b>11-2-59</b>	
23a. BURIAL, CREMATION, OR REMOVAL (Specify)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)				
<b>Removal</b>		<b>11-4-59</b>	<b>Mt Calvary Cem.</b>		<b>Kansas City Kansas</b>				
24. FUNERAL DIRECTOR <b>Dw Newman Sons K.C. Mo.</b>				25. DATE RECD. BY LOCAL REG. <b>11-3-59</b>		26. REGISTRAR'S SIGNATURE <b>Gene Brinshell</b>			

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 me

or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_

Signature of Student Embalmer

Signed

*Robert C. Heron*

Licensed Embalmer No. 4849

P. O. Address H. C. K.

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.