...URI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

'59 044267
STATE FILE NUMBER

FILED VS DEC 30 1959

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 6036

...MENDED

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: 35 years
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location): V A HOSPITAL — Inside Limits: Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MISSOURI — b. COUNTY: Jackson
c. CITY OR TOWN: KANSAS CITY — Inside Limits: Yes ☐ No ☐
d. STREET ADDRESS (If outside, give location): 931 NORTH MONROE — Reside on Farm: Yes ☐ No ☐

3. NAME OF DECEASED (Type or print): First CARL — Middle Jackson — Last MOORE

4. DATE OF DEATH: Month December — Day 13, — Year 1959

5. SEX: Male
6. COLOR OR RACE: White
7. Married ☐ Never Married ☐ Widowed ☒ Divorced ☐
8. DATE OF BIRTH: 3-27-88
9. AGE (last birthday): 71 — 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): Broom maker
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (City and state or country): Unknown
12. CITIZEN OF WHAT COUNTRY: U.S.A.

13a. FATHER'S NAME: Unknown
13b. MOTHER'S MAIDEN NAME: Unknown
14. NAME OF HUSBAND OR WIFE: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes, give war or dates of service): WWI
16. SOCIAL SECURITY NO.: 499-16-3193A
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: — INTERVAL BETWEEN ONSET AND DEATH

IMMEDIATE CAUSE (a): Bronchopneumonia, R&LLL

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c): Cerebral infarction, right

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): Pulmonary emphysema

PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
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 ☐ NOT WHILE AT WORK ☐ VA
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 December 8, 1959, to December 13, 1959 and last saw him on
Death occurred at 4:15 p m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): J. A. TURNER, M.D. — D. Jas. Turner M.D.
22b. ADDRESS: VA Hospital, Kansas City, Mo.
22c. DATE SIGNED: 12-14-59

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: 12/15/1959
23c. NAME OF CEMETERY OR CREMATORY: Memorial Park cemetery
23d. LOCATION (City, town, or county) (State): Kansas City Missouri

24. FUNERAL DIRECTOR — ADDRESS: D.W. Newcomers Sons 1331 Brush Creek Blvd. Kansas City Missouri
25. DATE RECD. BY LOCAL REG.: 12-15-59
26. REGISTRAR'S SIGNATURE: Neva Minshall

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

BY AFFIDAVIT OF

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_____ Signed Roger F. Fuller

Signature of Student Embalmer

Licensed Embalmer No. 4818

P. O. Address KC Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to com 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.