

FURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS DEC 3 0 1959

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5973

STATE FILE NUMBER

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

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. Institution: Residence before admission)	
a. COUNTY JACKSON	b. STATE MISSOURI c. COUNTY Jackson		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN KANSAS CITY	Length of stay in 1b 63 years	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 V A HOSPITAL	Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS 1115 TROOST	(If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print)	First ARTHUR	Middle EDWARD	Last SAUNDERS	4. DATE OF DEATH	Month December	Day 9,	Year 1959
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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 10-14-04	9. AGE (last birthday) 65	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Taxi cab driver	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Lees Summit, Missouri	12. CITIZEN OF WHAT COUNTRY U.S.A.
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13a. FATHER'S NAME James R. Saunders	13b. MOTHER'S MAIDEN NAME Ella L. Coy	14. NAME OF HUSBAND OR WIFE Rowe Saunders
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WWI	16. SOCIAL SECURITY NO. 495 07 9309	17. INFORMANT VA Hospital Official Records, K.C. Mo.	Address
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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 <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
IMMEDIATE CAUSE (a) Mucous bronchitis, severe with beginning bronchopneumonia		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Bullous emphysema	
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.

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.)
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year
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20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> VA 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
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11 I attended the deceased from **November 18, 1959** to **December 9, 1959**
Death occurred at **1:50** p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) ALBERT L. CHASSON, MD. <i>Albert L. Chason</i>	22b. ADDRESS VA Hospital, Kansas City, Mo.	22c. DATE SIGNED 12-10-59
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23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE DEC 11, 1959	23c. NAME OF CEMETERY OR CREMATORY MEMORIAL PARK	23d. LOCATION (City, town, or county) KANSAS CITY MO
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24. FUNERAL DIRECTOR D. W. NEWCOMER'S SONS K. C. MO.	25. DATE RECD. BY LOCAL REG. 12-11-59	26. REGISTRAR'S SIGNATURE <i>Newa Drinshall</i>
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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 Raymond M. Hardy

Licensed Embalmer No. 4913

P. O. Address Indep. Mo

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.