

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-023428

FILED VS JUL 13 1960

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 3402 STATE FILE NUMBER

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|--|--|---|--|---|--|--|---|--|--------|---|-------|--|--|
| 1. PLACE OF DEATH a. COUNTY JACKSON | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY JACKSON | | | | | | | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN KANSAS CITY | | Length of stay in 1b 40 Year | | c. CITY OR TOWN KANSAS CITY | | 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 | | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | d. STREET ADDRESS (If outside, give location) 3215 CAMPBELL | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | | | | | | |
| 3. NAME OF DECEASED (Type or print) First ROY Middle M. Last STROUD | | | | 4. DATE OF DEATH Month JUNE Day 27 Year 1960 | | | | | | | | | |
| 5. SEX MALE | | 6. COLOR OR RACE WHITE | | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | | 8. DATE OF BIRTH 4-1-78 | | 9. AGE (last birthday) 82 | | 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) Carpenter | | | 10b. KIND OF BUSINESS OR INDUSTRY Building Trade | | 11. BIRTHPLACE (City and state or country) Janesville, Wisconsin | | | 12. CITIZEN OF WHAT COUNTRY U.S.A. | | | | | |
| 13a. FATHER'S NAME William Stroud | | | | 13b. MOTHER'S MAIDEN NAME Mary Ford | | | | 14. NAME OF HUSBAND OR WIFE ELLA STROUD | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes 5-27-98 to 11-9-98 | | | 16. SOCIAL SECURITY NO. 187-10-6610 | | 17. INFORMANT 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: | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| IMMEDIATE CAUSE (a) Myocardial failure | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | | | | | | | | | | DUE TO (b) Hypopotassemia | | | |
| | | | | | | | | | | DUE TO (c) Diarrhea and cardiac decompensation | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Arteriosclerotic heart disease | | | | | | | | 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. VA attended the deceased from 6-24-60 to 6-27-60 Death occurred at 2:24 A.m. on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | | | | | | | | |
| 22a. SIGNATURE <i>[Signature]</i> (Degree or title) T. J. FRITZLEN, M.D. | | | | 22b. ADDRESS VA HOSPITAL, KANSAS CITY, MO. | | | | 22c. DATE SIGNED 6-27-60 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | | | 23d. LOCATION (City, town, or county) (State) | | | | | |
| Burial | | June 29, 1960 | | Peculiar Cemetery Peculiar Missouri | | | | | | | | | |
| 24. FUNERAL DIRECTOR Muehlebach | | | ADDRESS 6800 TROOST | | 25. DATE RECD. BY LOCAL REG. 6-28-60 | | 26. REGISTRAR'S SIGNATURE <i>[Signature]</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
or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed R. E. Nichols

Licensed Embalmer No. 4997

P. O. Address K. C. N.

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