RI DIVISION OF HEALTH — STANDARD CERTIFICATE OF DEATH

FILED VS JUL 26 1960

60-027138

STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 3653

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

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE KANSAS b. COUNTY W yandotte
c. CITY OR TOWN KANSAS CITY — Inside Limits: Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location) 431 WALKER — Reside on Farm: Yes ☐ No ☒

3. NAME OF DECEASED (Type or print) First: JAMES Middle: Last: SMITH
4. DATE OF DEATH Month, Day, Year: July 11, 1960
5. SEX: Male
6. COLOR OR RACE: Negro
7. Married ☐ Never Married ☒ Widowed ☐ Divorced ☐
8. DATE OF BIRTH: 12-21-35
9. AGE (last birthday): 24
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): Restaurant work
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (City and state or country): Drew, Mississippi
12. CITIZEN OF WHAT COUNTRY: U.S.A.
13a. FATHER'S NAME: unknown
13b. MOTHER'S MAIDEN NAME: Mary Smith
14. NAME OF HUSBAND OR WIFE: never married
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): 2-2-54 to 7-5-57
16. SOCIAL SECURITY NO.: 513-30-5993
17. INFORMANT: VA Hospital Official Rcds,K.C.Mo. Address: Mary Smith, 431 Walker,Kansas City, Kans

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Diffuse subarachnoid hemorrhage
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Thrombocytopenia
DUE TO (c) Acute monocytic leukemia
INTERVAL BETWEEN ONSET AND DEATH
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. ☐ 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 ☐
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
20f. CITY, TOWN, OR LOCATION COUNTY STATE

BY AFFIDAVIT OF

21. I attended the deceased from November 6, 1959 to July 11, 1960 and last saw him alive on
Death occurred at 8:05 a m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): T. J. FRITZLEN, M.D.
22b. ADDRESS: VA Hospital, Kansas City,Mo.
22c. DATE SIGNED: 7-11-60

23a. BURIAL, CREMATION, REMOVAL (Specify): removal
23b. DATE: 7-14-60
23c. NAME OF CEMETERY OR CREMATORY: Westlawn Cemetery
23d. LOCATION (City, town, or county) (State): Kansas City, Kansas

24. FUNERAL DIRECTOR ADDRESS: Mrs. Meek's Mortuary, K. C. Mo.
25. DATE REC'D BY LOCAL REG.: 7-13-60
26. REGISTRAR'S SIGNATURE: Neva Minshall

(Licensed Embalmer's Statement on Reverse Side)

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_____ Signed Millard B. Pas

Signature of Student Embalmer

Licensed Embalmer No. SD

P. O. Address K. C.

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