

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-008630

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

AMENDED

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 945

FILED VS MAR 13 1961

DATE AMENDED

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <b>JACKSON</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY <b>JACKSON</b>		
b. CITY (If outside corporate limits, give TOWNSHIP only) <b>KANSAS CITY, MISSOURI</b> Length <u>20 years</u> <u>12 Days</u>			c. CITY OR TOWN <b>KANSAS CITY, MO.</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>			d. STREET ADDRESS (If outside, give location) <b>2732 TROOST</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>CHARLES</b> Middle <b>EVANS</b> Last <b>ATWELL</b>			4. DATE OF DEATH Month <b>FEB</b> Day <b>20</b> Year <b>1961</b>		
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>6-16-20</b>	9. AGE (last birthday) <b>40</b>	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Cat driver</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>HANCOCK, MO.</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A</b>
13a. FATHER'S NAME <b>CHARLES M. ATWELL</b>		13b. MOTHER'S MAIDEN NAME <b>COBA SLOAN</b>		14. NAME OF HUSBAND OR WIFE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>YES 5-29-44 to 4-16-46</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>VA HOSPITAL RECORDS</b> 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) <b>Blood loss shock</b>					
DUE TO (b) <b>Hemorrhaging duodenal ulcer</b>					
DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Cirrhosis of the liver</b>					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 <input type="checkbox"/> a.m. <input type="checkbox"/> 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 <u>2-8-61</u> to <u>2-20-61</u> and last saw <sup>her</sup> him alive on <u>2-20-61</u> Death occurred at <u>4:35 AM 2-20-61</u> on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Type or print) <b>R. H. OWINGS, M.D.</b>			22b. ADDRESS <b>VA Hospital, Kansas City, Mo.</b>		22c. DATE SIGNED <b>2-20-61</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE <b>2-23-1961</b>	23c. NAME OF CEMETERY OR CREMATORY <b>EAST SLOPE CEM.</b>		23d. LOCATION (City, town, or county) (State) <b>REVERSIDE Mo.</b>	
24. FUNERAL DIRECTOR <b>D.W. NEWCOMER'S SONS N.K.C. Mo</b>		25. DATE RECD. BY LOCAL REG. <b>2-24-61</b>		26. REGISTRAR'S SIGNATURE <b>Ruth Long</b>	

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

*John W. Kallberg*

Licensed Embalmer No. 11049

P. O. Address No. Kansas

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.