

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-009119

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

AMENDED

Registration District No. 149
FILE 3 APR 10 1961

Primary Registration District No. 1002

Registrar's No. 1469

STATE FILE NUMBER

DATE AMENDED

POWERED UP ON THIS RECORD ARE AS FOLLOWS
 INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <u>JACKSON</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>JACKSON</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>KANSAS CITY</u>		Length of stay in 1b <u>70 years</u>		c. CITY OR TOWN <u>KANSAS CITY</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>V A HOSPITAL</u>				d. STREET ADDRESS <u>2401 EAST 10TH</u>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>JOHN</u> Middle <u>SHAFFER, AKA SCHAFFER</u> Last <u>SHAFFER</u>				4. DATE OF DEATH Month <u>March</u> Day <u>21</u> Year <u>1961</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>6-23-90</u>	
9. AGE (last birthday) <u>70</u>		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>		IF UNDER 24 HR Hours <u>0</u> Min. <u>0</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Hoisting engineer, retired</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>retired</u>		11. BIRTHPLACE (City and state or country) <u>Leavenworth, Kansas</u>	
12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>							
13a. FATHER'S NAME <u>William Shaffer</u>				13b. MOTHER'S MAIDEN NAME <u>Anna Meyernick</u>		14. NAME OF HUSBAND OR WIFE <u>Goldena Shaffer</u>	
15. WAS DECEASED EVER IN ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes WWI</u>				16. SOCIAL SECURITY NO.		17. INFORMANT <u>VA Hospital Official Rcds, Kansas City, Mo</u> Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Lymphosarcoma involving soft tissue of neck all lymph nodes and stomach.</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Old posterior myocardial infarction</u>						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 checked="" type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>VA</u>		20f. CITY, TOWN, OR LOCATION <u>VA Hospital, Kansas City, Mo.</u>		COUNTY _____ STATE _____	
21. I attended the deceased from <u>Feb. 17, 1961</u> to <u>March 21, 1961</u> Death occurred at <u>2:15</u> a.m. on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <u>T. J. Fritzlen</u> (Degree or title)				22b. ADDRESS <u>VA Hospital, Kansas City, Mo.</u>		22c. DATE SIGNED <u>3-21-61</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE <u>3-24-61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mt Calvary</u>		23d. LOCATION (City, town, or county) (State) <u>Kans City Kans</u>	
24. FUNERAL DIRECTOR <u>Zwnewermers Sons</u>				25. DATE RECD. BY LOCAL REG. <u>K.R.K. 3-22-61</u>		26. REGISTRAR'S SIGNATURE <u>Ruth Long</u>	

STATE OF MISSISSIPPI
 DEPARTMENT OF HEALTH
 BUREAU OF PUBLIC HEALTH
 DIVISION OF ANATOMY
 CERTIFICATE OF EMBALMING

No. _____
 Date _____
 Name of Deceased _____
 Age _____
 Sex _____
 Race _____
 Cause of Death _____
 Place of Death _____
 Name of Embalmer _____
 Address _____
 City _____ State _____
 License No. _____
 Signature of Embalmer _____
 Date _____

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 Robert E. Heron

Licensed Embalmer No. 4849
 P. O. Address H. P. Co.

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.