

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-033105

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

AMENDED

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4413 STATE FILE NUMBER

FILED SEP 25 1961

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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 18 years | 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, K.C., MO. | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) 433 W. 59th Terrace Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |

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| 3. NAME OF DECEASED (Type or print) First WILLIAM Middle NONE Last SCHOPFLIN | | | 4. DATE OF DEATH Month SEPTEMBER Day 2 Year 1961 | | |
| 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 1-4-16 | 9. AGE (last birthday) 45 | IF UNDER 1 YEAR Months Days Hours Min. |

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| 10. KIND OF BUSINESS OR INDUSTRY ASSISTANT TO VICE PRES. PLASTICS DIVISION | | 11. BIRTHPLACE (City and state or country) KANSAS CITY, KANSAS | | 12. CITIZEN OF WHAT COUNTRY U.S.A. | |
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| 13a. FATHER'S NAME FRANK SCHOPFLIN | | 13b. MOTHER'S MAIDEN NAME HELEN BACHAN | | 14. NAME OF HUSBAND OR WIFE KATHLEEN K. SCHOPFLIN | |
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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 WW II | | 17. INFORMANT Address Kathleen Schopflin Wife Kansas City, Mo Official Records VA Hospital, K.C., Mo. | |
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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: IMMEDIATE CAUSE (a) Cerebral edema postoperative 4 days DUE TO (b) Glioblastoma multiforme of right parietal lobe 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 (e) | | 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 | |
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| 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 | 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | |
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| 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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| 21. I attended the deceased from August 28, 1961 to Sept 2, 1961 Death occurred at 10:15 A.M. on the date stated above, and to the best of my knowledge, from the causes stated. | |
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| 22a. SIGNATURE S. H. CHOY, M.D. | (Degree or title) | 22b. ADDRESS VA Hospital, K.C., Mo. | 22c. DATE SIGNED 9-2-61 |
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| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | 23b. DATE SEPT. 5, 1961 | 23c. NAME OF CEMETERY OR CREMATORY CALVARY CEMETERY | 23d. LOCATION (City, town, or county) KANSAS CITY MISSOURI |
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| 24. FUNERAL DIRECTOR D. W. NEWCOMER'S SONS | ADDRESS 1331 BRUSH CR. KANSAS CITY MO. | 25. DATE RECD. BY LOCAL REG. 9-5-61 | 26. REGISTRAR'S SIGNATURE Ruth Long |
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DATE AMENDED
INSTEAD OF
SHOULD READ
ITEM NO.

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 me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed

Harold B. Estern

Licensed Embalmer No. 3135

P. O. Address

Harold B. Estern

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.