

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-61-036758

AMENDED

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 5131

STATE FILE NUMBER

FILED OCT 27 1961

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City		Length of stay in 1b 7 1/2 mos.	c. CITY OR TOWN Cameron 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) 603 N. Walnut Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last JENNINGS BRYAN ATKISSON			4. DATE OF DEATH Month Day Year October 14, 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 11-30-98	9. AGE (last birthday) 62
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cafe Operator		10b. KIND OF BUSINESS OR INDUSTRY Food	11. BIRTHPLACE (City and state or country) Mountain Grove, Mo.	12. CITIZEN OF WHAT COUNTRY USA

13a. FATHER'S NAME Charles B. Atkisson		13b. MOTHER'S MAIDEN NAME Carrie E. Mings		14. NAME OF HUSBAND OR WIFE Myrl Atkisson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WWI		16. SOCIAL SECURITY NO.		17. INFORMANT Address VA Hospital Records.	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary insufficiency.		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Bullous emphysema of lungs, severe.	
	DUE TO (c)	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Syphilitic aortic aneurysm, multiple (2)		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.)	
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 **March 2, 1961** to **October 14, 1961** and last saw him ~~live on~~
Death occurred at **7:50 PM** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <i>S.H. Choy</i>	(Degree or title) M. D.	22b. ADDRESS VA Hospital, Kansas City, Mo.	22c. DATE SIGNED 10-15-61
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23a. BURIAL, CREATION, REMOVAL (Specify) Burial	23b. DATE 10-18-61	23c. NAME OF CEMETERY OR CREMATORY Wheeling Cemetery	23d. LOCATION (City, town, or county) (State) Wheeling Mo.
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24. FUNERAL DIRECTOR D.W. Newcomer's Sons	ADDRESS 1331 Brush Creek	25. DATE RECD. BY LOCAL REG. 10-15-61	26. REGISTRAR'S SIGNATURE <i>Ruth H. Long</i>
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(Licensed Embalmer's Statement on Reverse Side)

DATE AMENDED

INSTEAD OF THIS RECORD ARE AS FOLLOWS

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

S.H. Choy

OCT 31 1961

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 O. Reich

Licensed Embalmer No. 4998

P. O. Address Kansas City,

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.