

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-036829

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 4888

STATE FILE NUMBER

AMENDED

FILES OCT 19 1961

1. PLACE OF DEATH a. COUNTY JACKSON		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY HENRY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN KANSAS CITY		Length of stay in 1b 14 days	c. CITY OR TOWN CLINTON 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) 328 W. Gravel Street Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First JOHN Middle RHODES Last CHAPIN			4. DATE OF DEATH Month September Day 30 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 2-9-95	9. AGE (last birthday) 66	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Construction Work		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Hoxie, Arkansas	12. CITIZEN OF WHAT COUNTRY U.S.A.	

13a. FATHER'S NAME Silas Chapin	13b. MOTHER'S MAIDEN NAME Milinda Meade	14. NAME OF HUSBAND OR WIFE Fern E. Chapin
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 OFFICAL RECORDS, K. C. MO.

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) CARDIAC STANDSTILL		
DUE TO (b) RESPIRATORY DISTRESS		
DUE TO (c) METASTATIC CARCENOMA		
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. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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 VA COUNTY VA STATE VA
21. VA attended the deceased from 9-16-61 to 9-30-61 Death occurred at 9:30 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.		

22a. SIGNATURE A. J. Ashman MD	22b. ADDRESS VA Hospital, K. C. Mo.	22c. DATE SIGNED 9-30-61
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL	23b. DATE 10-3-1961	23c. NAME OF CEMETERY OR CREMATORY FT. LEAVENWORTH NAT. Cem. Fort LEAVENWORTH, KANS.
24. FUNERAL DIRECTOR D.W. Newcomer's Sons No. K.C., Mo.	25. DATE RECD. BY LOCAL REG. 10-3-61	26. REGISTRAR'S SIGNATURE Ruth Long

(Licensed Embalmer's Statement on Reverse Side)

DATE AMENDED

INSTEAD OF

ITEM NO. SHOULD READ

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 John V. Ferrick Jr.
Licensed Embalmer No. 4848

P. O. Address K. 6, 17, Mo.

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.