

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-041244

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

AMENDED

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 5873 STATE FILE NUMBER

FILED DEC 11 1961

1. PLACE OF DEATH a. COUNTY JACKSON		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE KANSAS b. COUNTY Johnson	
b. CITY (If outside corporate limits, give TOWNSHIP only) KANSAS CITY		Length of stay in lb 4 mo 5 da	c. CITY OR TOWN SHAWNEE MISSION Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION V A HOSPITAL		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 4743 NEOSHO Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First WILLIAM Middle LYLE Last ROWLAND			4. DATE OF DEATH Month November Day 21 Year 1961		
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5. SEX Male	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 12-4-99	9. AGE (last birthday) 61	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Receiving Clerk	10b. KIND OF BUSINESS OR INDUSTRY Jewett-Sherman Mercantile Co.	11. BIRTHPLACE (City and state or country) Zarah, Kansas	12. CITIZEN OF WHAT COUNTRY U.S.A.
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13a. FATHER'S NAME John Rowland	13b. MOTHER'S MAIDEN NAME Margaret Loercher	14. NAME OF HUSBAND OR WIFE - None
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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 WWII	17. INFORMANT Address VA Hospital Official Records, 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) Carcinoma of lung DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH
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.)
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m.	Month, Day, Year
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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
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21. I attended the deceased from **July 16, 1961** to **November 21, 1961** and last saw him alive on _____
Death occurred at **4:30 a.m.** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE ROBERT W. BROWN, M.D.	22b. ADDRESS VA Hospital, Kansas City, Mo.	22c. DATE SIGNED 11-21-61
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23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 11-24-61	23c. NAME OF CEMETERY OR CREMATORY Johnson Co. Memorial Gardens Johnson County, Ks.	23d. LOCATION (City, town, or county) (State)
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24. FUNERAL DIRECTOR D. W. Newcomer's Sons	ADDRESS 1331 Brush Creek Blvd. Kansas City, Mo.	25. DATE RECD. BY LOCAL REG. 11-23-61	26. REGISTRAR'S SIGNATURE Ruth Long
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DATE AMENDED

INSTEAD OF

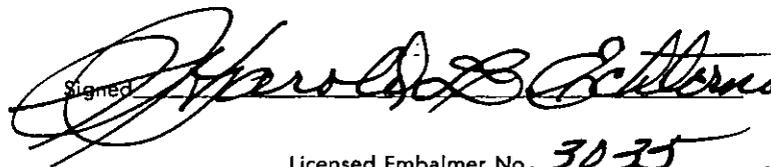
SHOULD READ

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 

Licensed Embalmer No. 3035
P. O. Address St. Charles

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.