

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

5659-63-039863
STATE FILE NUMBER

Registration District No. 147 Primary Registration District No. 1002 Registrar's No. 5659

DO NOT WRITE ON THIS STUB

AMENDED

VS 300 Rev. 4/59	DATE AMENDED
1	
2 <u>3x28</u>	
3	
4 <u>0</u>	
5 <u>1</u>	
6	
7 <u>0</u>	
8 <u>1</u>	
9 <u>181-0</u>	
10	
11	
12 <u>76-0</u>	
13	

USE BLACK INK OR TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

BY AFFIDAVIT OF William K. Gouffley MEDICAL CERTIFICATION

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, MISSOURI		Length of stay in 1b 3 MONTHS	c. CITY OR TOWN KANSAS CITY, MO. 1520 Will St.
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION VA HOSPITAL, KC, MO.		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 1520 Will St., Kc, Mo.
3. NAME OF DECEASED (Type or print) EARL J. DEWALD		4. DATE OF DEATH Month OCTOBER Day 20 Year 1963	
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 2/24/15
9. AGE (last birthday) 48		IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ODD JOBS		10b. KIND OF BUSINESS OR INDUSTRY ODD JOBS	11. BIRTHPLACE (City and state or country) KANSAS CITY, MO.
12. CITIZEN OF WHAT COUNTRY U.S.A.		13a. FATHER'S NAME WILLIAM DEWALD	
13b. MOTHER'S MAIDEN NAME EFFIE BATES		14. NAME OF HUSBAND OR WIFE MRS GRACE DEWALD	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES (If yes, give war or dates of service) 1-29/45 to 10/10/45		16. SOCIAL SECURITY NO. VA HOSP RECORDS (GRACE DEWALD (WIFE))	
17. INFORMANT 1520 Will Kc, Mo. VA HOSP RECORDS (GRACE DEWALD (WIFE))		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) UREMIA AND INANITION DUE TO (b) PARTIAL URETERAL OBSTRUCTION DUE TO (c) CARCINOMA OF THE URINARY BLADDER WITH LIVER METASTASIS 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 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 10/12/63 to 10/20/63 and last saw HEM him alive on 10/20/63 Death occurred at 4:45 AM 10/20/63 m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>William K. Gouffley</i>		22b. ADDRESS VA HOSPITAL, KANSAS CITY, MO	22c. DATE SIGNED 10-20-63
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE 10-22-63	23c. NAME OF CEMETERY OR CREMATORY COOL SPRINGS CEMETERY	23d. LOCATION (City, town, or county) WAYNE COUNTY, MO.
24. FUNERAL DIRECTOR KANSAS CITY MORTUARY SR		ADDRESS 4316 Troost	25. DATE RECD. BY LOCAL REG. 10-20-63
		26. REGISTRAR'S SIGNATURE <i>Bessie Smith</i>	

EXHIBIT - 100
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STATEMENT BY LICENSED EMBALMER

10-11

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 Forrest D. Caldwell

Licensed Embalmer No. 4714

P. O. Address K. E. Mrs.

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.