

FILED AUG 12 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **23529**
3296
Registrar's No.

BIRTH NO. **42107-49** REG. DIST. NO. **149** PRIMARY REG. DIST. NO. **1002**

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 OR TOWN Kansas City		c. CITY OR TOWN Kansas City	
c. LENGTH OF STAY (in this place) 1 day 13 1/2 hrs		d. STREET ADDRESS 1414 E 27th	
d. FULL NAME OF HOSPITAL OR INSTITUTION Fairmount Hospital			

3. NAME OF DECEASED (Type or Print) a. (First) Sam b. (Middle) Melnick c. (Last) Melnick			4. DATE OF DEATH (Month) (Day) (Year) July 26, 1949		
5. SEX Male		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED never married	
8. DATE OF BIRTH July 25, 1949		9. AGE (In years last birthday) 1 IF UNDER 1 YEAR Months 1 Days 12 IF UNDER 24 HRS. Hours 30 Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) X	
10b. KIND OF BUSINESS OR INDUSTRY X		11. BIRTHPLACE (State or foreign country) Missouri		12. CITIZEN OF WHAT COUNTRY? United States	

13a. FATHER'S NAME Sam Saitz		13b. MOTHER'S MAIDEN NAME Olga Melnick		14. NAME OF HUSBAND OR WIFE X	
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) X		16. SOCIAL SECURITY NO. X		17. INFORMANT'S SIGNATURE OR NAME Fairmount Hospital K.C. Mo.	
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pulmonary Atelectasis		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause* (a) stating the underlying cause last.		DUE TO (b) Prematurity & Immaturity			
DUE TO (c)		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION 7625		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from **July 25, 1949, to July 26, 1949**, that I last saw the deceased alive on **July 26, 1949**, and that death occurred at **6:20 P. m.**, from the causes and on the date stated above.

23a. SIGNATURE Robert F. Wortmann (Degree or title) M. D.		23b. ADDRESS 570 Popplewood Bldg		23c. DATE SIGNED 7-27-49	
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE July 29, 1949		24c. NAME OF CEMETERY OR CREMATORY Green Lawn Mortuary	
24d. LOCATION (City, town, or county) (State) Kansas City, Missouri		25. FUNERAL DIRECTOR'S SIGNATURE G. A. P. Doehler ADDRESS K. C. Mo.			
DATE REC'D BY LOCAL REG. 7-29-49		REGISTRAR'S SIGNATURE Sheldine Holmes			

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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.....

Not Embalmed

Student Embalmer No.

working under my personal supervision.

Signed.....

Signed.....

Student Embalmer

Licensed Embalmer No.....

P. O. Address.....

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 this body is not embalmed, fact should be so stated above.