

FILED NOV 17 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. **37424**
4705

BIRTH NO.		REG. DIST. NO. 149		PRIMARY REG. DIST. NO. 1002		Registrar's No.		
1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
a. COUNTY Jackson		b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kansas City		a. STATE Missouri		b. COUNTY Jackson		
d. FULL NAME OF HOSPITAL OR INSTITUTION 2800 East 10 St		c. LENGTH OF STAY (in this place) 3 yrs.		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kansas City		d. STREET ADDRESS (If rural, give location) 2800 East 10 St.		
3. NAME OF DECEASED (Type or Print)			a. (First) FRANK		b. (Middle) J.		c. (Last) LUTZ	
4. DATE OF DEATH (Month) (Day) (Year)		Nov. 2-1951		9. AGE (In years last birthday)		IF UNDER 1 YEAR Months Days		
5. SEX Male		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) single		8. DATE OF BIRTH 8-10-1886		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Soda Fountain Erector		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) 9		12. CITIZEN OF WHAT COUNTRY U.S.		
13a. FATHER'S NAME Anthony Lutz			13b. MOTHER'S MAIDEN NAME Lois Flannigan		14. NAME OF HUSBAND OR WIFE none			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) yes W.W. I		16. SOCIAL SECURITY NO. none		17. INFORMANT'S SIGNATURE OR NAME John A. Lutz		ADDRESS Erie, Pa.		
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH		
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral hemorrhage		ANTECEDENT CAUSES DUE TO (b) Generalized arteriosclerosis				2 days		
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		DUE TO (c)				yes		
II. OTHER SIGNIFICANT CONDITIONS		Conditions contributing to the death but not related to the disease or condition causing death.				331X		
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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 Sept 3, 1951 , to Nov 2, 1951 , that I last saw the deceased alive on Nov 1, 1951 , and that death occurred at 2:30 A.M. , from the causes and on the date stated above.								
23a. SIGNATURE B. Goldblatt MD				23b. ADDRESS Oreola Huron Bldg KEK		23c. DATE SIGNED Nov/5/51		
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 11-9-51		24c. NAME OF CEMETERY OR CREMATORY -- Nat'l. Cem.		24d. LOCATION (City, town, or county) (State) Ft. Leavenworth, Kans.		
DATE REC'D BY LOCAL REG 11-5-51		REGISTRAR'S SIGNATURE Geraldine Holmes		25. FUNERAL DIRECTOR'S SIGNATURE M. R. Fowler		ADDRESS K.C. mo		

(Licensed Embalmer's Statement on Reverse Side)

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

240
③
K.
P. H. ...

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
Student Embalmer

Signed Joe B. Yoder
Licensed Embalmer No. 4173

P. O. Address A. C. 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 this body is not embalmed, fact should be so stated above.