

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **1419**
291
Registrar's No.

FILED FEB 14 1953

BIRTH NO. _____		REG. DIST. NO. 149		PRIMARY REG. DIST. NO. 1002		Registrar's No.	
1. PLACE OF DEATH a. COUNTY Jackson				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Mo b. COUNTY Jackson			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kansas city		c. LENGTH OF STAY (In this place) 4 1/2 yrs		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kansas city			
d. FULL NAME OF HOSPITAL OR INSTITUTION Menorah				d. STREET ADDRESS (If rural, give location) 447 Highland			
3. NAME OF DECEASED (Type or Print) a. (First) Judy b. (Middle) Gail c. (Last) Fifield			4. DATE OF DEATH (Month) (Day) (Year) 1-19-53				
5. SEX Female	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Child	8. DATE OF BIRTH 11-3-43	9. AGE (In years last birthday) 9 yrs	10. MONTHS 9	11. YEARS 9	12. HOURS 9
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and State or Foreign Country) California		12. CITIZEN OF WHAT COUNTRY? U.S.	
13a. FATHER'S NAME Howard Fifield		13b. MOTHER'S MAIDEN NAME Esther Goldstein		14. NAME OF HUSBAND OR WIFE Esther Fifield			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT'S SIGNATURE OR NAME Esther Goldstein ADDRESS 447 Highland			
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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute disseminated lupus erythematosus ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH 2 yrs	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" 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) (Min)		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 Apr 1951 to 18 Jan 1953 , that I last saw the deceased alive on 19 Jan 1953 , and that death occurred at 10:30 m., from the causes and on the date stated above.							
23a. SIGNATURE Julius M. Kantor M.D. (Degree or title)				23b. ADDRESS Argyle Bldg K.C. Mo		23c. DATE SIGNED 19 Jan 1953	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 1-19-53	24c. NAME OF CEMETERY OR CREMATORY Mt. Carmel		24d. LOCATION (City, town, or county) (State) Kansas City, Mo.		
DATE REC'D BY LOCAL REG. 1-19-53		REGISTRAR'S SIGNATURE Sheraldine Smith		25. FUNERAL DIRECTOR'S SIGNATURE Louis Tom Home		ADDRESS K.C. Mo	

(Licensed Embalmer's Statement on Reverse Side)

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.

Student

Student Embalmer

Signed _____

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.