

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. **1643**

FILED FEB 14 1953

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BIRTH NO. _____		REG. DIST. NO. <u>149</u>		PRIMARY REG. DIST. NO. <u>1001</u>		Registrar's No. _____	
1. PLACE OF DEATH a. COUNTY <u>Jackson</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Jackson</u>			
b. CITY (If outside corporate limits, write RURAL and give township) <u>Kansas City</u>		c. LENGTH OF STAY (In this place) <u>years</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>Kansas City</u>		d. STREET ADDRESS (If rural, give location) <u>7400 Belleview</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St. Lukes</u>				3. NAME OF DECEASED a. (First) <u>Reuben</u> b. (Middle) _____ c. (Last) <u>Spector</u>			
4. DATE OF DEATH <u>Jan 15, 1953</u>		5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	
8. DATE OF BIRTH <u>Dec. 22, 1895</u>		9. AGE (In years last birthday) <u>57</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Co-owner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Spectors Restaurant</u>	
11. BIRTHPLACE (City and State or Foreign Country) <u>Kansas City, Kan.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13a. FATHER'S NAME <u>Isaac Spector</u>		13b. MOTHER'S MAIDEN NAME <u>Nettie (Unknown)</u>		14. NAME OF HUSBAND OR WIFE <u>Helen Spector</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Unknown</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Mrs. Sam Glass</u> ADDRESS <u>3000 W. 74th</u>			
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) <u>acute cardiac failure</u> ANTECEDENT CAUSES <u>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</u> DUE TO (b) <u>arteriosclerotic heart disease</u> DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS <u>Conditions contributing to the death but not related to the disease or condition causing death.</u>				INTERVAL BETWEEN ONSET AND DEATH <u>4200</u>	
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 <u>Jan 13, 1953</u> , to <u>Jan 15, 1953</u> , that I last saw the deceased alive on <u>Jan 15, 1953</u> , and that death occurred at <u>12:05 P. M.</u> , from the causes and on the date stated above.							
23a. SIGNATURE <u>A. W. Robinson</u> (Degree or title) <u>A. W. Robinson M.D. MD</u>				23b. ADDRESS <u>4635 Wyandotte, K.C., Mo.</u>		23c. DATE SIGNED <u>Jan 17 53</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>Jan. 18, 1953</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Mt. Carmel</u>		24d. LOCATION (City, town, or county) (State) <u>Kansas City, Mo.</u>	
DATE REC'D BY LOCAL REG. <u>1-17-53</u>		REGISTRAR'S SIGNATURE <u>Seraldine Smith</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Louis Funeral Home</u> ADDRESS <u>K. C. Mo.</u>			

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed _____

Ray Buffington

Licensed Embalmer No. 2756

P. O. Address: N.C. 760

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.