

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

9873

State File No. \_\_\_\_\_

No. 300  
10-48

FILED APR 9 1953

1615

|   |                              |   |  |   |  |   |  |
|---|------------------------------|---|--|---|--|---|--|
| BIRTH NO. _____   |                              | REG. DIST. NO. <u>149</u>   |  | PRIMARY REG. DIST. NO. <u>1002</u>  |  | Registrar's No. <u>1615</u>   |  |
| 1. PLACE OF DEATH<br>a. COUNTY <u>Jackson</u>   |                              |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).<br>a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u> |  |   |  |
| b. CITY (If outside corporate limits, write RURAL and give township)<br><u>Kansas City</u>  |                              | c. LENGTH OF STAY (in this place)<br><u>63 yrs.</u>   |  | c. CITY (If outside corporate limits, write RURAL and give township):<br><u>Kansas City</u>   |  |   |  |
| d. FULL NAME OF HOSPITAL OR INSTITUTION<br><u>Menorah Hospital</u>  |                              |   |  | d. STREET ADDRESS (If rural, give location)<br><u>115 W. Armour</u>   |  |   |  |
| 3. NAME OF DECEASED<br>(Type or Print)  |                              | a. (First)<br><u>MILTON</u>   |  | b. (Middle)<br><u>M.</u>  |  | c. (Last)<br><u>HELLMAN</u>   |  |
| 4. DATE OF DEATH  |                              | (Month) <u>3</u>  |  | (Day) <u>21</u>   |  | (Year) <u>53</u>  |  |
| 5. SEX<br><u>M</u>  | 6. COLOR OR RACE<br><u>W</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)<br><u>Single</u>   |  | 8. DATE OF BIRTH<br><u>Oct. 21, 1873</u>  |  | 9. AGE (in years last birthday)<br><u>79</u>  | IF UNDER 1 YEAR<br>Months _____ Days _____ |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Salesman</u>  |                              | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Adv. Specialty</u>  |  | 11. BIRTHPLACE (City and State or Foreign Country)<br><u>Kansas</u>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>  |  |
| 13a. FATHER'S NAME<br><u>Max Hellman</u>  |                              | 13b. MOTHER'S MAIDEN NAME<br><u>Matilda Marohn</u>  |  | 14. NAME OF HUSBAND OR WIFE<br><u>---</u>   |  |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><u>No</u>   |                              | 16. SOCIAL SECURITY NO.<br><u>196-26-9989</u>   |  | 17. INFORMANT'S SIGNATURE OR NAME<br><u>Gus Sanders</u>   |  | ADDRESS<br><u>1425 Oak</u>  |  |
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br>*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<br>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>cardiac failure</u><br><br>ANTECEDENT CAUSES<br>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.<br>DUE TO (b) <u>arteriosclerosis &amp; atherosclerosis</u><br>DUE TO (c) _____<br><br>II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death.<br><u>Suprapubic prostatectomy</u> |  |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>48 hrs.</u><br><u>48 hrs.</u><br><u>610X</u><br><u>72 hrs.</u> |  |
| 19a. DATE OF OPERATION<br><u>3-18-53</u>  |                              | 19b. MAJOR FINDINGS OF OPERATION<br><u>Benign prostatic hypertrophy</u>   |  |   |  | 20. AUTOPSY?<br>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) (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 <u>3-12</u> , 19 <u>53</u> , to <u>3-21</u> , 19 <u>53</u> that I last saw the deceased alive on <u>3-21</u> , 19 <u>53</u> and that death occurred at <u>7:20</u> a.m., from the causes and on the date stated above. |                              |   |  |   |  |   |  |
| 23a. SIGNATURE<br><u>W. W. Leifer</u>   |                              | (Degree or title) _____   |  | 23b. ADDRESS<br><u>MD 1103 Grand Ave</u>  |  | 23c. DATE SIGNED<br><u>3-21-53</u>  |  |
| 24a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Removal</u>   |                              | 24b. DATE<br><u>3/22/53</u>   |  | 24c. NAME OF CEMETERY OR CREMATORY<br><u>Fort Scott, Kansas</u>   |  | 24d. LOCATION (City, town, or county) (State)   |  |
| DATE REC'D BY LOCAL REG.<br><u>3-21-53</u>  |                              | REGISTRAR'S SIGNATURE<br><u>Sheraldine Smith</u>  |  | 25. FUNERAL DIRECTOR'S SIGNATURE<br><u>STINE-McCLURE</u>  |  | ADDRESS<br><u>Kansas City, Mo.</u>  |  |

(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 \_\_\_\_\_

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student .....  
Student Embalmer

Signed Eugene J. Kennon

Licensed Embalmer No. 4623

P. O. Address Kansas City, 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.