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.48

FILED AUG 19 1953

THE DIVISION OF HEALTH OF MISSOURI
# STANDARD CERTIFICATE OF DEATH

State File No. 28551

BIRTH NO. _____ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. 3829

**1. PLACE OF DEATH**
a. COUNTY Jackson
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Kansas City
c. LENGTH OF STAY (In this place) 48 Yrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Trinity Lutheran Hospital

**2. USUAL RESIDENCE** (Where deceased lived. If institution: residence before admission).
a. STATE Missouri
b. COUNTY Jackson
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Kansas City
d. STREET ADDRESS (If rural, give location) 4426 Summit

3718 0

**3. NAME OF DECEASED** (Type or Print)
a. (First) James
b. (Middle)
c. (Last) CHORN

**4. DATE OF DEATH** (Month) (Day) (Year) August 2 1953

**5. SEX** Male 0
**6. COLOR OR RACE** White
**7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED** (Specify) Married
**8. DATE OF BIRTH** 7 July 1872
**9. AGE** (In years last birthday) 81 — If under 1 year: Months Days — If under 24 hrs.: Hours Min.

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired) Salesman
**10b. KIND OF BUSINESS OR INDUSTRY** Livestock
**11. BIRTHPLACE** (City and State or Foreign Country) Normal, Ill.
**12. CITIZEN OF WHAT COUNTRY?** U.S.

**13a. FATHER'S NAME** J. Chorn
**13b. MOTHER'S MAIDEN NAME** R. Quisenberry
**14. NAME OF HUSBAND OR WIFE** AAlice Chorn

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unknown) No (If yes, give war or dates of service) X X X
**16. SOCIAL SECURITY NO.** None
**17. INFORMANT'S SIGNATURE OR NAME** Alice Chorn **ADDRESS** 4426 Summit K. C. Mo.

**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, asthenia, etc. It means the disease, injury, or complication which caused death.*

**MEDICAL CERTIFICATION**

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) cerebral & pulmonary edema — 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) cardiac hypertrophy & dilitation (hypertension)
DUE TO (c) arteriosclerosis

II. OTHER SIGNIFICANT CONDITIONS
*Conditions contributing to the death but not related to the disease or condition causing death.*
45 00

**19a. DATE OF OPERATION**
**19b. MAJOR FINDINGS OF OPERATION**
**20. AUTOPSY?** YES ☒ NO ☐

**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) m.
**21e. INJURY OCCURRED** WHILE AT WORK ☐ NOT WHILE AT WORK ☐
**21f. HOW DID INJURY OCCUR?**

22. *I hereby certify that I attended the deceased from* _____, 19___, *to* _____, 19___, *that I last saw the deceased alive on* _____, 19___ *and that death occurred at* _____ m., *from the causes and on the date stated above.*

**23a. SIGNATURE** Jack H. Hill (Degree or title) M. D.
**23b. ADDRESS** 3001 Wyandotte St + 168 Mo.
**23c. DATE SIGNED** 2 Aug 53

**24a. BURIAL, CREMATION, REMOVAL** (Specify) Burial
**24b. DATE** 4 August 53
**24c. NAME OF CEMETERY OR CREMATORY** Crown Hill
**24d. LOCATION** (City, town, or county) (State) Excelsior Springs, Mo.

**DATE REC'D BY LOCAL REG.** 8-3-53
**REGISTRAR'S SIGNATURE** Geraldine Smith
**25. FUNERAL DIRECTOR'S SIGNATURE** **ADDRESS** Floral Hills Memorial Chapels 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.....

..... Student Embalmer No. .....

working under my personal supervision.

Student .....
Student Embalmer

Signed Lloyd C. McCord

Licensed Embalmer No. 4653

P. O. Address K. C. Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

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