

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **1552**
5

FILED JAN 27 1954

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

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD
Walter P. Jacobs

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. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kansas City	
c. LENGTH OF STAY (in this place) 48 yrs		d. STREET ADDRESS (If rural, give location) 620 Roman y Road	
d. FULL NAME OF HOSPITAL OR INSTITUTION Menorah Medical Center		e. ADDRESS 620 Roman y Road	
3. NAME OF DECEASED (Type or Print) a. (First) LENA b. (Middle) _____ c. (Last) STONE		4. DATE OF DEATH (Month) (Day) (Year) 1 1 54	
5. SEX F	6. COLOR OR RACE Wh	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED, (Specify) Widowed 2	8. DATE OF BIRTH 8-27-87
9. AGE (In years: last birthday) 66		10. CAUSE OF DEATH (Give kind of work done during most of working life, even if retired) House wife	11. BIRTHPLACE (City and State or Foreign Country) Poland
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Nathan Lux	
14. MOTHER'S MAIDEN NAME Anna Talman		15. NAME OF DECEASED Arnold	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO. None	
18. INFORMANT'S SIGNATURE OR NAME Martin Stone		19. ADDRESS 6000 W 57th	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		MEDICAL CERTIFICATION	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Atrophy cerebellum, pars (n.m.o.)		INTERVAL BETWEEN ONSET AND DEATH 6 yrs	
*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 (b) _____	
ANTECEDENT CAUSES (Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last.)		DUE TO (c) _____	
II. OTHER SIGNIFICANT CONDITIONS (Conditions contributing to the death but not related to the disease or condition causing death.) Braichopneumonia, RUL, PLL		35-5X	
19a. DATE OF OPERATION		20. AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
19b. MAJOR FINDINGS OF OPERATION		21. ACCIDENT SUICIDE HOMICIDE (Specify)	
21a. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21b. (CITY; TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21c. TIME OF INJURY (Month) (Day) (Year) (Hour)		21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21e. HOW DID INJURY OCCUR?		22. I hereby certify that I attended the deceased from 1-1-54 , to 1-7-54 , that I last saw the deceased alive on 1-1-54 , and that death occurred at 4:40 pm. , from the causes and on the date stated above.	
23a. SIGNATURE OF REGISTRAR Walter P. Jacobs		23b. ADDRESS 310 Bryant Bldg	
23c. DATE SIGNED 1/2/54		24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	
24b. DATE 1-3-54		24c. NAME OF CEMETERY OR CREMATORY Sheffield	
24d. LOCATION (City, town, or county) (State) Kansas City, Mo.		25. FUNERAL DIRECTOR'S SIGNATURE Louis Funeral Home	
DATE REC'D BY LOCAL REG. 1-2-54		REGISTRAR'S SIGNATURE Geraldine Smith	
25. FUNERAL DIRECTOR'S SIGNATURE Louis Funeral Home		ADDRESS K.C. Mo.	

Discontinued

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 *A. L. Louis*

Licensed Embalmer No. *3110*

P. O. Address *K. E., 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.