

27523

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 3852

FILED AUG 27 1954

No. 300
10-48

BIRTH NO. _____		REG. DIST. NO. <u>149</u>		PRIMARY REG. DIST. NO. <u>1002</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>Missouri</u> b. COUNTY <u>Jackson</u>					
b. CITY (If outside corporate limits, write RURAL and give town) <u>Kansas City</u>		c. LENGTH OF STAY (In this place) <u>40 yrs</u>		c. CITY OR TOWN <u>Kansas City</u>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Menorah Hospital</u>				e. STREET ADDRESS (If rural, give location) <u>3227 Lockridge</u>					
3. NAME OF DECEASED (Type or Print) a. (First) <u>IDA</u>			b. (Middle) _____		c. (Last) <u>MASTERS</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>8 6 1954</u>		
5. SEX <u>Fe</u>		6. COLOR OR RACE <u>Wh</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Divorced</u>		8. DATE OF BIRTH <u>5-7-1880</u>		9. AGE (In years by birthday) <u>74</u> IF UNDER 1 YEAR Months Days IF UNDER 1 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret'd Nurse</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Practical</u>			11. BIRTHPLACE (City and State or Foreign Country) <u>Berlin, Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>William F. Hubert</u>			13b. MOTHER'S MAIDEN NAME <u>Louise Henschke</u>			14. NAME OF HUSBAND OR WIFE <u>XX</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes or unknown) <u>No</u> (If yes, give war or dates of service) <u>XX</u>			16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Clarence Masters, 6644 Paseo, KC Mo.</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 Myocardial Infarction</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>Coronary Arteriosclerosis</u> DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS <u>Hyperbemic Heart Disease</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u> <u>5 years</u> <u>5 years</u>	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION <u>4201</u>						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) _____		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>Aug 1, 1949</u> to <u>Aug 6, 1954</u> , that I last saw the deceased alive on <u>Aug 6, 1954</u> , and that death occurred at <u>1:00 P.M.</u> , from the causes and on the date stated above.									
23a. SIGNATURE <u>Jack W. Wolf</u> (Degree or title) <u>M.D.</u>				23b. ADDRESS <u>415 E. 63 Kansas City, Mo</u>			23c. DATE SIGNED <u>8/7/54</u>		
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>8-9-54</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park</u>		24d. LOCATION (City, town, or county) (State) <u>Kansas City Mo.</u>			
DATE REC'D BY LOCAL REG. <u>8-7-54</u>		REGISTRAR'S SIGNATURE <u>Sheraldine Smith</u>			25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Magner Funeral Home, K C 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.....
Signature of Student Embalmer

Signed *Alvin R. Haunscho*.....

Licensed Embalmer No. *H/10*

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

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.