

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

FILED APR 25 1956

State File No. **13465**  
Registrar's No. **1529**

BIRTH NO. _____		REG. DIST. NO. <u>149</u>		PRIMARY REG. DIST. NO. <u>1002</u>		Registrar's No. <u>1529</u>			
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 town or township) <u>Kansas City</u>		c. LENGTH OF STAY (In this place) <u>5 yrs.</u> <u>13 days</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 Medical Center</u>				e. STREET ADDRESS (If rural, give location) <u>4430 Benton</u>					
3. NAME OF DECEASED (Type or Print) a. (First) <u>David</u>			b. (Middle) <u>Neil</u>		c. (Last) <u>Rosen</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>April 8 1956</u>		
5. SEX <u>M</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED, DIVORCED (Specify)		8. DATE OF BIRTH <u>Mar 27 1951</u>		9. AGE (In years last birthday) <u>5</u> 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)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and State or Foreign Country) <u>Kansas City, Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13a. FATHER'S NAME <u>Charles Rosen</u>			13b. MOTHER'S MAIDEN NAME <u>Bertha Rose</u>			14. NAME OF HUSBAND OR WIFE _____			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME <u>Charles Rosen</u>			ADDRESS <u>Home</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, asphyxia, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Acute Lymphatic Leukemia</u>  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____  II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH <u>10 mo.</u>  <u>2040</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) _____ m.		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>May</u> , 19 <u>55</u> , to <u>8/ apr</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>8 apr</u> , 19 <u>56</u> , and that death occurred at <u>5:20 PM</u> , from the causes and on the date stated above.									
23a. SIGNATURE <u>Julius M. Kantor</u> (Degree or title) <u>MD</u>				23b. ADDRESS <u>701 E 63 K.C. Mo.</u>				23c. DATE SIGNED <u>8/4/56</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>4-9-56</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Sheffield</u>		24d. LOCATION (City, town, or county) (State) <u>Kansas City, Mo.</u>			
DATE REC'D BY LOCAL REG. <u>4-9-56</u>		REGISTRAR'S SIGNATURE <u>Neva Marshall</u>			25. FUNERAL DIRECTOR'S SIGNATURE <u>Louis Fun'l Home</u>		ADDRESS <u>K.C. Mo.</u>		

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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**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.....  
*Guy Buffington*

Licensed Embalmer No. 275

P. O. Address N.C. 740

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.