

Health,
Welfare
Public
Service

300
1-56

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
William Lowe Mundy
MEDICAL CERTIFICATION

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED NOV 2 - 1956

34067

STATE FILE NUMBER

4500

Registration District No. 149 Primary Registration District No. 1002

Registrar's No.

1. PLACE OF DEATH a. COUNTY Jackson				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Calif b. COUNTY Los Angeles			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN Beverly Hills, Calif.		Outside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Menorah Medical Center			Length of stay in lb 2 da		d. STREET ADDRESS 420 So. Dohney Drive		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last Dora B. Koskoff				4. DATE OF DEATH Month Day Year October 14, 1956			
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9-12-94		9. AGE (In years last birthday) 62 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) Denver, Colo.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Aaron Gardenswartz				14. MOTHER'S MAIDEN NAME Anna (Unknown)			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Dave Koskoff		Address Home	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Coronary atherosclerosis DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 2 days. 7 months 4201	
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour Month, Day, Year a. m. p. m.							
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION		COUNTY STATE	
21. I attended the deceased from 10-11-56 to 10-14-56 and last saw her alive on 10-14-56. Death occurred at 8:30 p. m. on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE William Lowe Mundy M.D.				22b. ADDRESS 1103 Grand		22c. DATE SIGNED 10-15-56	
23a. Burial, CREMATION, REMOVAL (Specify) Removal		23b. DATE 10-16-56	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State) Los Angeles, Calif.		
24. FUNERAL DIRECTOR Louis Fun'l Home			ADDRESS K.C. Mo.	25. DATE RECD. BY LOCAL REG. 10-16-56		26. REGISTRAR'S SIGNATURE Neva Munschell	

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was e
by me, or by Student Embalmer No.....
working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed. *Henry Buffington*

Licensed Embalmer No. 2

P. O. Address *N.C.*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING.
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.