

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

4721

STATE FILE NUMBER

557

FILED FEB 27 1957

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 Mo. b. COUNTY Jackson	
b. CITY (If outside corporate limits, give TOWNSHIP only) Inside Limits OR TOWN Kansas City Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN Kansas City Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 3521 Forest Length of stay in lb 64 yrs.		d. STREET ADDRESS (If outside, give location) 3521 Forest Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First SAM Middle G Last GLASS			4. DATE OF DEATH Month Feb Day 2 Year 1957			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-15-76		9. AGE (In years last birthday) 80	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - Merchants		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) Lithuania	12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Max Glass			14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Lillian Mallon 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) Cornary occlusion			INTERVAL BETWEEN ONSET AND DEATH 3 min
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) arteriosclerotic heart disease			12 yrs
DUE TO (c)			4206
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

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 Jan 6, 1957 to Feb. 2, 1957 and last saw him alive on Jan 28, 1957 Death occurred at 3521 Forest m on the date stated above; and to the best of my knowledge, from the causes stated.				
22a. SIGNATURE J. S. Hoffman (Degree or title) D		22b. ADDRESS 330 Professional Bldg	22c. DATE SIGNED 2-3-57	

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 2-4-57	23c. NAME OF CEMETERY OR CREMATORY Sheffield	23d. LOCATION (City, town, or county) (State) Kansas City, Mo
24. FUNERAL DIRECTOR Louis Fun'l Home ADDRESS K.C. Mo.	25. DATE RECD. BY LOCAL REG. 2-5-57	26. REGISTRAR'S SIGNATURE Neva Marshall	

(Licensed Embalmer's Statement on Reverse Side)

All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes. No symptoms will be listed. All standard nomenclature in item 18. Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
J. S. Hoffman

MEDICAL CERTIFICATION

300
1-56

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 Ruffington

Licensed Embalmer No. *27*

P. O. Address *N.C. N.*

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