

Health,
, & Welfare
S. Public
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v. 1-57

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed.
All diseases in Part I must be causally related.

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

17184

STATE FILE NUMBER

FILED MAY 21 1957

Registration District No. 149 Primary Registration District No. 1001 Registrar's No. 2109

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) OR TOWN Kansas City		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		420 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 Gen'l Hosp.			Length of stay in lb 50 yrs.		d. STREET ADDRESS (If outside, give location) 2729 Troost		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Harry Middle Levitow Last Levitow				4. DATE OF DEATH Month 5 Day 4 Year 57				
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July - 1894		9. AGE (In years last birthday) 62	IF UNDER 1 YEAR Months 6 Days 0 Hours 0 Min. 0	IF UNDER 24 HRS. Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - Real Estate Salesman			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) Russia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME Herman D. Levitow			13b. MOTHER'S MAIDEN NAME Sarah Leah Estrin			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) No			16. SOCIAL SECURITY NO. None		17. INFORMANT Herbert Kasovitz Address 6837 Brookside			
18. CAUSE OF DEATH (Enter only one cause per line in (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pending Autopsy Report and cerebral hemorrhage							INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) encephalomalacia of right Cerebrum					332X	
		DUE TO (c) severe calcific arteriosclerosis						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Diabetes mellitus, alcoholism, cirrhosis of liver							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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 5-4-57 to 5-4-57 and last saw her alive on 5-4-57 Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE B. I. Barnes, M.D. (Degree or title) D					22b. ADDRESS Gen - Hosp #1 K.C. Mo		22c. DATE SIGNED	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 5-5-57	23c. NAME OF CEMETERY OR CREMATORY Blue Ridge		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. 5-4-57		26. REGISTRAR'S SIGNATURE Preva Marshall			

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

J. Linen

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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 *Gay Buffington*
Licensed Embalmer No. *2756*
P. O. Address *X. L. Mrs.*

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.