

Health,
Welfare
Public
Service

FILED AUG 30 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

28256

STATE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 3769

800
-57

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri 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"/>	Inside Limits Yes <input checked="" 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. 30 YRS.	STREET ADDRESS (If outside, give location) 5725 Virginia
		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print)			4. DATE OF DEATH	
First Frank	Middle C.	Last Harvey	Month August 11	Day 1957

5. SEX Male	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 6-22-77	9. AGE (In years last birthday) 80	IF UNDER 1 YEAR Months 8 Days 0	IF UNDER 24 HRS. Hours 0 Min. 0
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Insurance Director	10b. KIND OF BUSINESS OR INDUSTRY Employers Insurance Co.	11. BIRTHPLACE (City and state or country) Quincy, Ill.	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME William Harvey	13b. MOTHER'S MAIDEN NAME Julia	14. NAME OF HUSBAND OR WIFE Mary E. Harvey
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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. 49-32-5392	17. INFORMANT Address Miss Dorothy Ewing - K.C. Mo.
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Standstill		INTERVAL BETWEEN ONSET AND DEATH 4330
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Conduction - defect DUE TO (c) Sclerosis of the conduction system	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Arteriosclerosis of the vessels		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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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.)
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20c. TIME OF INJURY Hour 11 a.m. 00 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 _____
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21. I attended the deceased from 8-2-57 to 8-11-57 and last saw her alive on 8-10-57 Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.	
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22a. SIGNATURE S. M. Shapiro M.D. (Degree or title)	22b. ADDRESS 706 E 63 - Suite 201	22c. DATE SIGNED 8-11-57
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23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE 8-13-57	23c. NAME OF CEMETERY OR CREMATORY Memorial Park	23d. LOCATION (City, town, or county) (State) Kansas City Mo.
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24. FUNERAL DIRECTOR Wornall Funeral Home	ADDRESS K.C. Mo.	25. DATE RECD. BY LOCAL REG. 8-12-57	26. REGISTRAR'S SIGNATURE Reva Minshall
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(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

L. M. Shapiro



4-20-53

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 Jimmy S. Hucksheim

Licensed Embalmer No. 4092 P. O. Address Overland Park, Mo.

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.