

Health, & Welfare Public Service

FILED NOV 14 1957

STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER 4931

Registration District No. 149 Primary Registration District No. 1002

3. 300 0
1-57

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"/>	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 Research Hosp		Length of stay in lb 20 Yrs	d. STREET ADDRESS (If outside, give location) 2619 Campbell		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First JACOB Middle C Last LONGAN			4. DATE OF DEATH Month October Day 23 Year 1957		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 22 1868	9. AGE (In years birthday) 89	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) Retired		10b. KIND OF BUSINESS OR INDUSTRY Lawyer	11. BIRTHPLACE (City and state or country) Osceola Missouri		12. CITIZEN OF WHAT COUNTRY? USA
13a. FATHER'S NAME Longan		13b. MOTHER'S MAIDEN NAME unknown		14. NAME OF HUSBAND OR WIFE Nola Belle Longan	
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 Address Mrs James Pappas St Louis Missouri		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis					INTERVAL BETWEEN ONSET AND DEATH Two Weeks
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) Hypertension Pulmonary Congest		6 days	
		DUE TO (c) Hypertension		4201 6 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) myocardial Degeneration Heart					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <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 Sept. 9, 1957 , to Oct. 23, 1957 , and last saw him alive on Oct. 22, 1957 . Death occurred at 6:17 a.m. 10/23/57 on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) Harold A. Pallett M.D.			22b. ADDRESS 1132 Prof. Blvd. KC Mo		22c. DATE SIGNED 10/23/57
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 10/25/57	23c. NAME OF CEMETERY OR CREMATORY Mt Washington Cemetery		23d. LOCATION (City, town, or county) (State) Kansas City Missouri
24. FUNERAL DIRECTOR ADDRESS Sheil Funeral Home Kansas City Mo			25. DATE RECD. BY LOCAL REG. 10-24-57		26. REGISTRAR'S SIGNATURE neva minshall

Harold A. Pallett USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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.

(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 embalmed by me, or by, Student Embalmer No. working under my personal supervision.

Student Signature of Student Embalmer

Signed *Thomas A. Smith*

Licensed Embalmer No. *4954* P. O. Address *X.P.M.*

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.