

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-018301

STATE FILE NUMBER
2234

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 2234

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
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION VA Hospital		Length of stay in lb 71 yrs	d. STREET ADDRESS (If outside, give location) 3400 Campbell

3. NAME OF DECEASED (Type or print) First Middle Last AUGUST KATZ			4. DATE OF DEATH Month Day Year May 1, 1958		
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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 April 26, 1876	9. AGE (In years) 77 yrs	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - Farmer	10b. KIND OF BUSINESS OR INDUSTRY Farming	11. BIRTHPLACE (City and state or county) New York State	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME -- Joseph A. Katz	13b. MOTHER'S MAIDEN NAME -- Annie -----	14. NAME OF HUSBAND OR WIFE Nellie H. Katz
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) Yes Spanish-American	16. SOCIAL SECURITY NO. 496 24 2409	17. INFORMANT VA Hospital Official Records	Address
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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) Cerebral thrombosis		INTERVAL BETWEEN ONSET AND DEATH 332 X
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Cerebral arteriosclerosis	
	DUE TO (c)	
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.)
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20c. TIME OF INJURY Hour Month, Day, Year p.m.	20d. INJURY OCCURRED WHILE AT <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. Attended the deceased from April 24, 1958 to May 1, 1958 Death occurred at 7:40 p.m. on the date stated above; and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE D. P. Perry (Degree or title) M.D.	22b. ADDRESS VA Hospital, K. C. Mo.	22c. DATE SIGNED 5-1-58
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23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 5-3-58	23c. NAME OF CEMETERY OR CREMATORY Fairview Mausoleum	23d. LOCATION (City, town, or county) (State) Northbrook Mo
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24. FUNERAL DIRECTOR Deitch Funeral Home	ADDRESS	25. DATE RECD. BY LOCAL REG. 5-2-58	26. REGISTRAR'S SIGNATURE Neva Minshall
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All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

5. 300
1-57

84

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 *Burt W. Gibson*

Licensed Embalmer No. *2961*

P. O. Address *Carrollton, Va.*

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.