

Health,  
& Welfare  
Public  
Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-025483  
STATE FILE NUMBER  
3322

FILED JUL 25 1958 Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 3322

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Jackson</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kansas City</b>		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 <b>Menorah Medical Center</b>		Length of stay in 1b —	d. STREET ADDRESS (If outside, give location) <b>408 W. 96th</b>
		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <b>Ray</b> Middle <b>Friedson</b> Last <b>Friedson</b>			4. DATE OF DEATH Month <b>7</b> Day <b>4</b> Year <b>58</b>			
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5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11-8-80</b>	9. AGE (In years last birthday) <b>77</b>	IF UNDER 1 YEAR Months <b>7</b> Days <b>1</b>	IF UNDER 24 HRS. Hours <b>1</b> Min. <b>0</b>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	10b. KIND OF BUSINESS OR INDUSTRY —	11. BIRTHPLACE (City and state or country) <b>Latvia</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
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13a. FATHER'S NAME —	13b. MOTHER'S MAIDEN NAME —	14. NAME OF HUSBAND OR WIFE <b>Morris Friedson</b>
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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) <b>NO</b>	16. SOCIAL SECURITY NO. —	17. INFORMANT <b>Ira Friedson</b>	Address <b>1225 W. 70th Terr.</b>
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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) <b>Carcinoma of lung</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 year</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____		1034
DUE TO (c) _____		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (e) <b>Essential Hypertension</b>		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 <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> 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 <b>Kansas City, Mo.</b>	COUNTY <b>Mo.</b>	STATE <b>Mo.</b>
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21. I attended the deceased from <b>1947</b> to <b>July 4, 1958</b> and last saw her alive on <b>July 3, 1958</b> Death occurred at <b>2:45 AM.</b> on the date stated above; and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE <b>Jack W. Way M.D.</b>	(Degree or title) <b>D</b>	22b. ADDRESS <b>409 E. 63 St. Kansas City, Mo.</b>	22c. DATE SIGNED <b>July 4, 1958</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>7/6/58</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Carmel</b>	23d. LOCATION (City, town, or county) (State) <b>Kansas City Missouri</b>
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24. FUNERAL DIRECTOR <b>J.P. Louts</b>	ADDRESS <b>3400 Woodland</b>	25. DATE RECD. BY LOCAL REG. <b>7-6-58</b>	26. REGISTRAR'S SIGNATURE <b>Neva Marshall</b>
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION  
Jack W. Wolf

All diseases in Part I must be causally related.

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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 *Guy Buffington*

Licensed Embalmer No. .... 756

P. O. Address ..... N. C. 110

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.