Health, & Welfare Public Service

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THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

58-036452
STATE FILE NUMBER

FILED OCT 23 1958 Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4707

1. PLACE OF DEATH
a. COUNTY Jackson
b. CITY OR TOWN (If outside corporate limits, give TOWNSHIP only) Kansas City — Inside Limits Yes [X] No [ ]
c. FULL NAME OF HOSPITAL OR INSTITUTION Menorah Medical Center — Length of stay in Ib 30 Yrs

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY Jackson
c. CITY OR TOWN Kansas City — Inside Limits Yes [X] No [ ]
d. STREET ADDRESS (If outside, give location) 434 East 73rd — Reside on Farm Yes [ ] No [X]

3. NAME OF DECEASED (Type or print) First: Helen Middle: Last: Kars

4. DATE OF DEATH Month Day Year: October 5th, 1958

5. SEX Female

6. COLOR OR RACE White

7. MARRIED [X] **NEVER MARRIED** [ ] **WIDOWED** [ ] **DIVORCED** [ ]

8. DATE OF BIRTH March APPROX.

9. AGE (In years last birthday) 48 — 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) Housewife

10b. KIND OF BUSINESS OR INDUSTRY Home

11. BIRTHPLACE (City and state or country) Poland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME Jake Yaskolka

13b. MOTHER'S MAIDEN NAME Edith---------

14. NAME OF HUSBAND OR WIFE Aaron Kars

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service) NO

16. SOCIAL SECURITY NO. -----

17. INFORMANT Address: Menorah Medical Center

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Liposarcoma c̄ generalized metastases — INTERVAL BETWEEN ONSET AND DEATH 2½ yrs.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) abdomen.
DUE TO (c) 1971
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 [ ] NO [X]

20a. ACCIDENT [ ] **SUICIDE** [ ] **HOMICIDE** [ ]

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK [ ] **NOT WHILE AT WORK** [ ]

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 1955, to Oct. 5, 1958 and last saw her alive on Oct. 5, 1958
Death occurred at 7:40 p.m. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE E. J. Twin, M.D. (Degree or title)

22b. ADDRESS 701 E. 63rd K.C. 10, Mo.

22c. DATE SIGNED Oct. 5, 1958

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial

23b. DATE Oct. 7 1958

23c. NAME OF CEMETERY OR CREMATORY Sheffield

23d. LOCATION (City, town, or county) (State) Kansas City, Mo.

24. FUNERAL DIRECTOR J.P. Louis Funeral Home K.C. MO.

25. DATE RECD. BY LOCAL REG. 10-6-58

26. REGISTRAR'S SIGNATURE Neva Minshall

(Licensed Embalmer's Statement on Reverse Side)

MEDICAL CERTIFICATION

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

E. J. Twin

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Dec 3-8 [illegible]

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. 2756

P. O. Address K.C. 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.