

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-039934
STATE FILE NUMBER
3219

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 3219

FILED NOV 19 1958

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kansas City</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Kansas City</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>2129 Madison</u> Length of stay in lb <u>30 yrs.</u>		d. STREET ADDRESS (If outside, give location) <u>2129 Madison</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Alcadio</u> Middle <u></u> Last <u>Estrada</u>		4. DATE OF DEATH Month <u>11</u> Day <u>3</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-11-1890</u>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		9b. KIND OF BUSINESS OR INDUSTRY <u>R.C. Terminal RR</u>	9c. AGE (In years last birthday) <u>68</u> IF UNDER 1 YEAR: Months <u>0</u> Days <u>0</u> IF UNDER 24 HRS.: Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>R.C. Terminal RR</u>	10c. BIRTHPLACE (City and state or country) <u>Mexico</u>
11. BIRTHPLACE (City and state or country) <u>Mexico</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13a. FATHER'S NAME <u>Pedro Estrada</u>		13b. MOTHER'S MAIDEN NAME <u>Refugia Rosales</u>	
14. NAME OF HUSBAND OR WIFE <u>Maria Estrada</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO. <u>unknown</u>		17. INFORMANT <u>Maria Estrada</u> Address <u>Same</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Hypertensive cardiovascular disease</u> DUE TO (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>4291</u>			INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>Unknown</u>
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.) <u>4291</u>	
20c. TIME OF INJURY Hour <u></u> Month, Day, Year <u></u> a.m. <u></u> p.m. <u></u>		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 <u>11-3-58</u> to <u>11-3-58</u> and last saw him alive on <u>11-3-58</u> Death occurred at <u>2129 Madison 10:30 a.m.</u> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Nicola Jaime M.D.</u>		22b. ADDRESS <u>715 Westport Road</u>	
22c. DATE SIGNED <u>11-4-58</u>		23a. BURIAL, CREMATION, OR REMOVAL (Specify)	
23b. DATE <u>11-5-58</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mt. St. Marys</u>	
23d. LOCATION (City, town, or county) (State) <u>Kansas City, Mo.</u>		24. FUNERAL DIRECTOR <u>Weilert's: 2332 Monitor Pl. K.C.Mo.</u>	
25. DATE RECD. BY LOCAL REG. <u>11-4-58</u>		26. REGISTRAR'S SIGNATURE <u>neva munschall</u>	

5. 300
1-57

All diseases in Part I must be causally related. No symptoms will be listed.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION



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 B. E. Walnut

Licensed Embalmer No. 4075

P. O. Address R. C. 8, Ma.

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.