

Health,
& Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-039952

STATE FILE NUMBER

FILED NOV 24 1958

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 5305

300
1-57

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MO b. COUNTY Jackson	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City MO		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 Turner Resting Home 5 MONTHS		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) 2800 E 10th St Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Walter R. Middle Fritz Last -			4. DATE OF DEATH Month 11 Day 6 Year 1958		
---	--	--	---	--	--

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 6-27-1878	9. AGE (In years last birthday) 80	IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	IF UNDER 24 HRS. Hours 0 Min. 0
--------------------	-------------------------------	---	--------------------------------------	--	---	--

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer	10b. KIND OF BUSINESS OR INDUSTRY ---	11. BIRTHPLACE (City and state or country) Rodding Penn.	12. CITIZEN OF WHAT COUNTRY? USA
---	---	--	--

13a. FATHER'S NAME Fritz	13b. MOTHER'S MAIDEN NAME R.	14. NAME OF HUSBAND OR WIFE ---
------------------------------------	--	---

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes <input checked="" type="checkbox"/> or unknown) (If yes, give war or dates of service) no	16. SOCIAL SECURITY NO. ---	17. INFORMANT Walter E Fritz Address 1874 S Pyle Kansas City, Mo.
---	---------------------------------------	--

18. CAUSE OF DEATH (Enter only one cause on one line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 4 years	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) arteriosclerosis		4 years
	DUE TO (c) ---		---
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 4500		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 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 11-1-58 to 11-6-58 and last saw her/him alive on 11-6-58 Death occurred at 7:25 p.m. on the date stated above; and to the best of my knowledge, from the causes stated.

22. SIGNATURE (Degree or title) Frank Paul Laurezana MD	22b. ADDRESS 728 1/2 white ave	22c. DATE SIGNED 11-6-58
---	--	------------------------------------

23a. BURIAL, CREMATION, REMOVAL Removal	23b. DATE 11-10-1958	23c. NAME OF CEMETERY OR CREMATORY Maple Hill Cem	23d. LOCATION (City, town, or county) (State) Kansas City, Kansas
---	--------------------------------	---	---

24. FUNERAL DIRECTOR Lawrence Bess	ADDRESS KC MO	25. DATE RECD. BY LOCAL REG. 11-9-58	26. REGISTRAR'S SIGNATURE Neva Minshall
--	-------------------------	--	---

(Licensed Embalmer's Statement on Reverse Side)

All diseases in Part I must be causally related.

MEDICAL CERTIFICATION
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Frank Paul Laurezana

Dr Frank Lauritzen
Nov 6 1958 7:35 PM



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 *Leonard Santino*

Licensed Embalmer No. *4554*

P. O. Address *Ke 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.