

Health, Welfare, Public Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-001193

STATE FILE NUMBER

1958 Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 353

300
-57

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 type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>General Hospital</u>		Length of stay in lb <u>9 years</u>	d. STREET ADDRESS (If outside, give location) <u>1803 E. 29th</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Rollin</u> Middle <u>Carlisle</u> Last <u>BEARD</u>			4. DATE OF DEATH Month <u>1</u> Day <u>17</u> Year <u>59</u>			
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5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 4, 1903</u>	9. AGE (In years last birthday) <u>55</u>	IF UNDER 1 YEAR Months <u>5</u> Days <u>5</u> Hours <u>5</u> Min.	IF UNDER 24 MRS. Months <u>5</u> Days <u>5</u> Hours <u>5</u> Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Billy Mount</u>	11. BIRTHPLACE (City and state or country) <u>Casey County, Ky</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
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13a. FATHER'S NAME <u>John A. Beard</u>	13b. MOTHER'S MAIDEN NAME <u>Bettie Lee Williams</u>	NAME OF HUSBAND OR WIFE <u>none</u>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, unknown) (If yes, give war or dates of service) <u>No</u>	16. SOCIAL SECURITY NO. <u>524-34-8004</u>	17. INFORMANT <u>Edna Lee Smith, 3324 Virginia</u>	Address <u>K.C. Mo.</u>
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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) <u>Cirrhosis of liver</u>		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) _____	
	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 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 _____ a.m. _____ p.m.	20d. 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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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
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21. I attended the deceased from <u>10-6-58</u> to <u>1-17-59</u> and last saw ^{him} alive on <u>1-17-59</u> Death occurred at <u>9:15 A.M.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE <u>Abraham Gelpert</u> (Degree or title) <u>2</u>	22b. ADDRESS <u>24th & Cherry</u>	22c. DATE SIGNED <u>1-18-59</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <u>1-20-59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Moriah Cemetery</u>	23d. LOCATION (City, town, or county) <u>Kansas City, Mo.</u> (State)
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24. FUNERAL DIRECTOR <u>Simon Mortuary, Kansas City, Mo.</u>	ADDRESS	25. DATE REC'D BY LOCAL REG. <u>1-19-59</u>	26. REGISTRAR'S SIGNATURE <u>Neva Minshall</u>
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(Licensed Embalmer's Statement on Reverse Side)

Abraham Gelpert in Use Only Black Ink or Ribbon Type Write if Possible

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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 *John R. Gidman*

Licensed Embalmer No. *4531*

P. O. Address *Kansas City*

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.