

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-001444

STATE FILE NUMBER

256

FILED JAN 28 1959

Registration District No. 149

Primary Registration District No. 1001

Registrar's No.

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>40 yrs.</u>	d. STREET ADDRESS (If outside, give location) <u>3230 Flora</u>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>IDA</u> Middle <u>LORVINE</u> Last <u>MONROE</u>				4. DATE OF DEATH Month <u>1</u> Day <u>13</u> Year <u>59</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb-18-1882</u>	9. AGE (In years less birthday) <u>76</u>	IF UNDER 1 YEAR Months <u>-</u> Days <u>-</u>	IF UNDER 24 HRS. Hours <u>-</u> Min. <u>-</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>		11. BIRTHPLACE (City and state or country) <u>Blainstown Iowa</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Salomon Hodges</u>		13b. MOTHER'S MAIDEN NAME <u>Electra Sophia Gustafson</u>		14. NAME OF HUSBAND OR WIFE <u>James Henry Monroe</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>496-09-0801A</u>		17. INFORMANT <u>Samuel Monroe</u>		Address <u>Garden City, Mo.</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>Generalized arteriosclerosis</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)		4	
PART II. OTHER SIGNIFICANT CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Diabetes mellitus, mild, acute cystitis</u>						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 <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>1-6-59</u> to <u>1-13-59</u> and last saw ^{her} alive on <u>1-13-59</u> Death occurred at <u>2:30 A.M.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <u>Abraham Galperin</u> (Degree or title) <u>0</u>			22b. ADDRESS <u>24th & Cherry</u>		22c. DATE SIGNED <u>1-13-59</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>1-16-1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Floral Hill Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Kansas City, Mo.</u>			
24. FUNERAL DIRECTOR <u>C.H. Blackman</u>		ADDRESS <u>5501 S.W. 2nd St. K.C. Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>1-15-59</u>	26. REGISTRAR'S SIGNATURE <u>Neva Minshall</u>			

(Licensed Embalmer's Statement on Reverse Side)

All diseases in Part I must be causally related.

Abraham Galperin, M.D. 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 *W. C. Quinn*

Licensed Embalmer No. *4879*

P. O. Address *H.C. 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.