Health, Welfare Public Service

300
1-57

FILED FEB 27 1959

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-005702
STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 10.02 Registrar's No. 804

1. PLACE OF DEATH
a. COUNTY Jackson
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City — Inside Limits Yes [X] No [ ]
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 2726 Bellview — Length of stay in 1b: 15 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 2726 Belleview (If outside, give location) — Reside on Farm Yes [ ] No [X]

3. NAME OF DECEASED (Type or print): First Casimira; Middle Acero; Last Lopez

4. DATE OF DEATH: Month 2; Day 9; Year 1959

5. SEX: Female

6. COLOR OR RACE: White

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

8. DATE OF BIRTH: 3-5-1895

9. AGE (In years last birthday): 63 — 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): Mexico

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

13a. FATHER'S NAME: Guadalupe Acero

13b. MOTHER'S MAIDEN NAME: Frances DeSotos

14. NAME OF HUSBAND OR WIFE: Atanacio Lopez

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

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Atanacio Lopez — Address: 2726 Belleview K.C., Mo.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinomatosis — INTERVAL BETWEEN ONSET AND DEATH:
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Carcinoma - Stomach — 12 mo.
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 [ ] 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 Nov '58, to present and last saw her/him alive on 5. Feb 59.
Death occurred at 9 Feb 59, on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): Buford T. Casebolt MD

22b. ADDRESS: 4000 Belleview K.C. Mo.

22c. DATE SIGNED: 11 Feb 59.

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal

23b. DATE: 2-13-1959

23c. NAME OF CEMETERY OR CREMATORY: Mount Calvary Cemetery

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

24. FUNERAL DIRECTOR ADDRESS: Weilert Funeral Homes (VI) K.C., Mo.

25. DATE RECD. BY LOCAL REG.: 2-12-59

26. REGISTRAR'S SIGNATURE: Neva Minshall

(Licensed Embalmer's Statement on Reverse Side)

All diseases in Part I must be causally related.

Buford T. Casebolt USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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 .....

Licensed Embalmer No. .....

P. O. Address .....

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.