Health, Welfare Public Service

300 -57

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-005792
STATE FILE NUMBER

FILED MAR 9 1959 Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 932

1. PLACE OF DEATH
a. COUNTY Jackson
b. CITY OR TOWN (If outside corporate limits, give TOWNSHIP only) Kansas City — Inside Limits Yes [X] No [ ]
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) Menorah Hospital — Length of stay in 1b 45 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 (If outside, give location) 1213 Wyandotte — Reside on Farm Yes [ ] No [X]

3. NAME OF DECEASED (Type or print) First Floye Middle E. Last Paul

4. DATE OF DEATH Month 2 Day 17 Year 59

5. SEX Fe
6. COLOR OR RACE Wh
7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]
8. DATE OF BIRTH 11-18-1872
9. AGE (In years on birthday) 86 — 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) At Home
10b. KIND OF BUSINESS OR INDUSTRY xx
11. BIRTHPLACE (City and state or country) Jasper County, Iowa
12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME Joseph Thompson
13b. MOTHER'S MAIDEN NAME Hulda C. Cool
14. NAME OF HUSBAND OR WIFE Dr. John B. Paul

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) xx
16. SOCIAL SECURITY NO. None
17. INFORMANT Otto Schmid, Address Kansas City 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) Ventricular Fibrillation
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b)
DUE TO (c) Arteriosclerotic Heart disease
INTERVAL BETWEEN ONSET AND DEATH

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 1-1-58, to 2-17-59 and last saw her/him alive on 2-17-59
Death occurred at 3:15 P.M. m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) David Waxman, MD
22b. ADDRESS 484 Project
22c. DATE SIGNED 2-20-59

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE 2-20-59
23c. NAME OF CEMETERY OR CREMATORY Forest Hill Cemetery
23d. LOCATION (City, town, or county) Kansas City, (State) Mo.

24. FUNERAL DIRECTOR Wagner Funeral Home. ADDRESS KC Mo
25. DATE RECD. BY LOCAL REG. 2-18-59
26. REGISTRAR'S SIGNATURE Neva Minshall

(Licensed Embalmer's Statement on Reverse Side)

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

David Waxman

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 Alvin R. Hauenschild

Licensed Embalmer No. 4159

P. O. Address K. C. 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.