

Health,  
Welfare  
Public  
Service

FILED FEB 27 1959

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-005794  
STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1000 Registrar No. 770

300  
1-57

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) <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 checked="" 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 1b <u>      </u>	d. STREET ADDRESS (If outside, give location) <u>711 Admiral</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>KITTIE</u> Middle <u>HATFIE</u> Last <u>PAYNE</u>			4. DATE OF DEATH Month <u>2</u> Day <u>7</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>Jul 12, 1912</u>
9. AGE (In years last birthday) <u>46</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>      </u>	11. BIRTHPLACE (City and state or country) <u>Quitman, Mo.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13a. FATHER'S NAME <u>Amasa Miller</u>	13b. MOTHER'S MAIDEN NAME <u>Unknown</u>
14. NAME OF HUSBAND OR WIFE <u>Unknown</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>None</u>
17. INFORMANT <u>Clarence Payne (Son)</u>		Address <u>6817 Chaumiere Rd K.C. 16, 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>Bilateral hemorrhagic aspiration</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>type bronchopneumonia</u> DUE TO (c) <u>      </u>			INTERVAL BETWEEN ONSET AND DEATH <u>      </u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>      </u>			19. WAS AUTOPSY PERFORMED? YES <input checked="" 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.) <u>      </u>	
20c. TIME OF INJURY Hour <u>      </u> Month, Day, Year a.m. <u>      </u> p.m. <u>      </u>		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.) <u>      </u>		20f. CITY, TOWN, OR LOCATION COUNTY STATE <u>      </u>	
21. I attended the deceased from <u>2-5-59</u> to <u>2-7-59</u> and last saw <sup>her</sup> <sub>him</sub> alive on <u>2-7-59</u> Death occurred at <u>9:55 AM</u> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>Alvician Telpen</u> (Degree or title)		22b. ADDRESS <u>24th &amp; Cherry</u>	22c. DATE SIGNED <u>2-9-59</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Feb. 10, 1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Greenlawn Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Kansas City, Mo.</u>
24. FUNERAL DIRECTOR <u>Peter B. Lapetina, K.C., Mo.</u> ADDRESS		25. DATE RECD. BY LOCAL REG. <u>2-10-59</u>	26. REGISTRAR'S SIGNATURE <u>Oliver Marshall</u>

Abraham Galperin Use only BLACK INK OR RIBBON TYPEWRITE 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 *Beau B. [Signature]*

Licensed Embalmer No. 4273

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.