

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-005881
STATE FILE NUMBER

FILED FEB 19 1959

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 643

300
-57

Health,
Welfare
Public
Service

Abraham Gelperin, M.D. Use ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION
All diseases in Part I must be causally related.

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 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 bed <u>45 YRS</u>	d. STREET ADDRESS (If outside, give location) <u>2518 Rochester</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>GEORGE</u> Middle <u>W</u> Last <u>SHERMAN</u>			4. DATE OF DEATH Month <u>2</u> Day <u>1</u> Year <u>59</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>SEP. 3 1884</u>
9. AGE (In years last birthday) <u>74</u>		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) <u>RETIRED LABORER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>GUSTON BACON</u>	11. BIRTHPLACE (City and state or country) <u>ATCHISON, KANSAS</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13a. FATHER'S NAME <u>THOMAS SHERMAN</u> <u>RETIRED LABORER</u>	13b. MOTHER'S MAIDEN NAME <u>NO RECORD</u>
14. NAME OF HUSBAND OR WIFE <u>LUIA MARIE SHERMAN</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>YES W.W.I</u>	16. SOCIAL SECURITY NO. <u>49-07-1204H</u>
17. INFORMANT <u>LUIA SHERMAN</u>		Address <u>2518 ROCHESTER</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>Clinic glomerulonephritis</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) _____			<u>5 1/2</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Bilateral Broncho-pneumonia</u>			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.)		
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. _____	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.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE		
21. I attended the deceased from <u>1-30-59</u> to <u>2-1-59</u> and last saw her ^{her} alive on <u>2-1-59</u> Death occurred at <u>10:05 AM</u> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Abraham Gelperin</u>		22b. ADDRESS <u>24th & Cherry</u>	22c. DATE SIGNED <u>2-2-59</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>HEMPHREY</u>	23b. DATE <u>2-5-59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>NATIONAL CEM.</u>	23d. LOCATION (City, town, or county) (State) <u>FORT LEVEN WORTH, KAN</u>
24. FUNERAL DIRECTOR <u>Sheel Funeral Home</u>	ADDRESS <u>H.C. Mann</u>	25. DATE RECD. BY LOCAL REG. <u>2-3-59</u>	26. REGISTRAR'S SIGNATURE <u>Drewa Minshall</u>

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 *Thomas S. Sheel*

Licensed Embalmer No. *4954*

P. O. Address *N.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.