

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-009607  
STATE FILE NUMBER  
1069

MAR 19 1959 Registration District No. 149 Primary Registration District No. 1502 Registrar's No.

300  
-57

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo</b> b. COUNTY <b>Jackson</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kansas City</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Kansas City</b> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Gen. Hosp. #1</b>		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) <b>1025 Highland</b> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>GEORGE</b> Middle Last <b>POLITE</b>			4. DATE OF DEATH Month <b>Feb.</b> Day <b>21,</b> Year <b>1959</b>	
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5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9-4-1889</b>	9. AGE (In years birthday) <b>69</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>Tennessee</b>	12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>
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13a. FATHER'S NAME <b>William Polite</b>	13b. MOTHER'S MAIDEN NAME <b>Mary Baxter</b>	14. NAME OF HUSBAND OR WIFE <b>Unknown</b>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT <b>None</b> <i>Manlove-Williams</i> Address - <i>1729 Lydia</i>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b>		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)	
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 <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.) <b>4"</b>
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20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.
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20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE 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 <b>K C. Mo.</b>	COUNTY <b>K C. Mo.</b>	STATE
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21. I attended the deceased from <b>12-10-59</b> to <b>2-21-59</b> and last saw her alive on <b>2-21-59</b> Death occurred at <b>9 a.m.</b> on the date stated above; and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE <i>Abraham Gelperin</i> (Degree or title)	22b. ADDRESS <b>Gen. Hosp. #1 KC, Mo.</b>	22c. DATE SIGNED <b>2-23-59</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Anatomical</b>	23b. DATE <b>2-26-59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>K C School Of Oestopathy</b>	23d. LOCATION (City, town, or county) (State) <b>K C. Mo.</b>
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24. FUNERAL DIRECTOR <b>Manlove-Williams</b>	ADDRESS <b>1729 Lydia</b>	25. DATE RECD. BY LOCAL REG. <b>2-26-59</b>	26. REGISTRAR'S SIGNATURE <i>Neva Marshall</i>
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All diseases in Part I must be causally related.  
 USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
 MEDICAL CERTIFICATION  
 Abraham Gelperin M.D.



**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.