

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-009685

STATE FILE NUMBER 1055

FILED MAR 19 1959 Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 1055

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1. PLACE OF DEATH a. COUNTY JACKSON		2. USUAL RESIDENCE (Where deceased lived prior to institution; Residence before admission) KANSAS b. COUNTY JOHNSON	
b. CITY (If outside corporate limits, give TOWNSHIP only) KANSAS City		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN MISSION, KS 91.50 8
c. FULL NAME OF (If NOT in hospital, give location) CHILDREN AGE Home		Length of stay in 1b 4 months	d. STREET ADDRESS (If outside, give location) 6229 Mission Rd

3. NAME OF DECEASED (Type or print) First: Hattie Middle: Last: SUPOFSKY			4. DATE OF DEATH Month: Feb Day: 29 Year: 1959	
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH APR. 21-1882	9. AGE (In years, months, days, hours, min.) 76
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, or if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (City and state or country) Poland 4	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME Louis FRIEDMAN	13b. MOTHER'S MAIDEN NAME Bessie Nenebeim	14. NAME OF HUSBAND OR WIFE MAX SUPOFSKY
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give dates of service) NO	16. SOCIAL SECURITY NO. —	17. INFORMANT HARRY SUPOFSKY 6229 Mission Rd
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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) Myocardial infarction Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Coronary thrombosis DUE TO (c) atherosclerosis		INTERVAL BETWEEN ONSET AND DEATH 5 days same
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Diabetes		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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.)
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20c. TIME OF INJURY Hour: a.m. p.m. Month, Day, Year	20d. INJURY OCCURRED WHILE AT WORK <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
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21. I attended the deceased from 1951 to 2-23-59 and last saw her alive on 2-23-59
Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE William Louis Mundy, M.D.	(Degree or title) D	22b. ADDRESS 1103 Grand	22c. DATE SIGNED 2-24-59
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23a. BURIAL, CREMATION, or MOV. (Specify) BURIAL	23b. DATE Feb 25-1959	23c. NAME OF CEMETERY OR CREMATORY MT CARMEL	23d. LOCATION (City, town, or county) (State) KANSAS CITY MO
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24. FUNERAL DIRECTOR J.P. Louis FUNERAL Home	ADDRESS K.C. Mo	25. DATE RECD. BY LOCAL REG. 2.25-59	26. REGISTRAR'S SIGNATURE Reva Minshall
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Will iam Lowe Mundy ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

MEDICAL CERTIFICATION

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 *Guy Buffington*

Licensed Embalmer No. *2756*

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.