

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-013464

STATE FILE NUMBER

2057

Registration District No. 149

Primary Registration District No. 1002

Registrar's No.

FILED MAY 13 1959

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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>		c. CITY OR TOWN <u>Kansas city</u>	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Gen. Hospital</u>		d. STREET ADDRESS (If outside, give location) <u>105 E 5th</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>HARRY Willie Myers MEYERS</u>		4. DATE OF DEATH Month Day Year <u>4 21 59</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 5, 1903</u>
10a. MAJOR OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unknown</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>?</u>	11. BIRTHPLACE (City and state or country) <u>?</u>
13a. FATHER'S NAME <u>?</u>		13b. MOTHER'S MAIDEN NAME <u>?</u>	14. NAME OF HUSBAND OR WIFE <u>?</u>
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, or unknown) (If yes, give war or dates of service) <u>Unk</u>		16. SOCIAL SECURITY NO. <u>—</u>	17. INFORMANT Address <u>K.C. Gen'l Hosp.</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>Laenneis Cirrhosis</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) _____			
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.) <u>5811</u>	
20c. TIME OF INJURY Hour Month, Day, Year 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>4-19-59</u> to <u>4-21-59</u> and last saw ^{her} _{him} alive on <u>4-21-59</u> Death occurred at <u>1:00 A M</u> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>Abraham Galperin</u> (Degree or title)		22b. ADDRESS <u>Gen. Hospital</u>	22c. DATE SIGNED <u>4-21-59</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>April 24, 59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>K.C. Dental College</u>	23d. LOCATION (City, town, or country) (State) <u>Kansas City, Mo.</u>
24. FUNERAL DIRECTOR ADDRESS <u>Peter B. Lapetina, K.C. Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>4-24-59</u>	26. REGISTRAR'S SIGNATURE <u>Wesley Marshall</u>

Abraham Galperin M.D. MEDICAL CERTIFICATION USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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 *Don 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.