

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-013589

STATE FILE NUMBER
1971

FILED MAY 13 1959 Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 1971

| | | | |
|---|----------------------------------|--|---|
| 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 type="checkbox"/> No <input type="checkbox"/> | 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> | | Length of stay in lb <u>Wife</u> | d. STREET ADDRESS (If outside, give location) <u>418 W 10th</u> |
| 3. NAME OF DECEASED (Type or print) First <u>Dorothy</u> Middle <u>Alice</u> Last <u>TRUAX</u> | | | 4. DATE OF DEATH Month <u>4</u> Day <u>18</u> Year <u>59</u> |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Feb 14 1904</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Maenueant</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Barber Shop</u> | 9. AGE (In years last birthday) <u>55</u> |
| 11. BIRTHPLACE (City and state or country) <u>Missouri</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13a. FATHER'S NAME <u>Hillman D. Truax</u> | | 13b. MOTHER'S MAIDEN NAME <u>Bettana Griffith</u> | |
| 14. NAME OF HUSBAND OR WIFE <u>Frank Truax</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>486-099108</u> | | 17. INFORMANT <u>Frank Truax</u> Address <u>704 1/2 Truman Rd</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>Lennies Crushoais with Crophaged Varices</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 WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 20f. CITY, TOWN, OR LOCATION <u>Kansas City</u> | | COUNTY <u>Missouri</u> STATE <u>Missouri</u> | |
| 21. I attended the deceased from <u>4-4-59</u> to <u>4-18-59</u> and last saw her ^{him} alive on <u>4-18-59</u> Death occurred at <u>8:45 AM</u> on the date stated above; and to the best of my knowledge, from the causes stated. | | | |
| 22a. SIGNATURE <u>Heuba Gelpovin</u> (Degree or title) <u>D</u> | | 22b. ADDRESS <u>Gen. Hospital</u> | |
| 22c. DATE SIGNED <u>4-19-59</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE <u>Apr. 20, 1959</u> | |
| 23c. NAME OF CEMETERY OR CREMATORY <u>Elmwood</u> | | 23d. LOCATION (City, town, or county) (State) <u>Kansas City, Missouri</u> | |
| 24. FUNERAL DIRECTOR <u>Stine & McClure, Kansas Coty, Missouri</u> | | 25. DATE RECD. BY LOCAL REG. <u>4-20-59</u> | |
| 26. REGISTRAR'S SIGNATURE <u>Neve Minshall</u> | | | |

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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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 *L. S. Walton*

Licensed Embalmer No. *2244*.....
P. O. Address *K. E. 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.