

Health,
Welfare
Public
Service

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THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-017726

FILED JUN 9 1959

Registration District No. 147 Primary Registration District No. 1002

STATE FILE NUMBER 2314
Registrar's No.

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Jackson	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Kansas City
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Menorah Hosp.		Length of stay in lb 46 Yrs.	d. STREET ADDRESS (If outside, give location) 801 West 67th Terr.
3. NAME OF DECEASED (Type or print) First Samuel Middle D. Last Goller			4. DATE OF DEATH Month 5 Day 8 Year 1959
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 27 1902
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Partner		10b. KIND OF BUSINESS OR INDUSTRY Printing	9. AGE (In years last birthday) 58
11. BIRTHPLACE (City and state or country) Kiev, Russia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME Rachmeal Goller		13b. MOTHER'S MAIDEN NAME Mary -----	14. NAME OF HUSBAND OR WIFE Edith Goller
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 498-30-2764	17. INFORMANT Address Edith Goller 801 West 67th Terr.
18. CAUSE OF DEATH (Enter only one cause on line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized Cochlear & Terminal bronchopneumonia DUE TO (b) Generalized Carcinomatosis DUE TO (c) Carcinoma of Kidney PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 180X
19. WAS AUTOPSY PERFORMED? YES <input checked="" 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. Month, Day, Year _____	
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 Jan 1937 to May 8, 1959 and last saw him alive on May 8, 1959 Death occurred at 10:00 P.M. m on the date stated above, and to the best of my knowledge, from the causes stated.		22a. SIGNATURE (Degree or title) L. M. Shapiro M.D.	
22b. ADDRESS 701 E 63rd St. Suite 201		22c. DATE SIGNED 5-9-59	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 5-10-1959	23c. NAME OF CEMETERY OR CREMATORY Mt Carmel Cemetery	23d. LOCATION (City, town, or county) (State) Kansas City, Missouri
24. FUNERAL DIRECTOR J.P. Louis Funeral Home, K.C., Mo.		25. DATE RECD. BY LOCAL REC. 5-9-59	26. REGISTRAR'S SIGNATURE rlv Marshall

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.
L. M. Shapiro

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 *Henry Buffington*

Licensed Embalmer No. 275

P. O. Address N.C. Ma

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.