

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-017759
STATE FILE NUMBER

FILED JUN 9 1959

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 2121

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1-57 D

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>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Gen. Hospital</u>			Length of stay in lb <u>20 yrs.</u>		d. STREET ADDRESS (If outside, give location) <u>4218 Cypress</u>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>BEN</u> Middle <u>F</u> Last <u>HOFFMAN</u>				4. DATE OF DEATH Month <u>4</u> Day <u>25</u> Year <u>59</u>					
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>AUG. 5 1876</u>		9. AGE (In years next birthday) <u>82</u> IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HRS.: Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CARPENTER RETIRED</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>SALINE COUNTY, MO.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13a. FATHER'S NAME <u>WILLAIMA HOFFMAN</u>			13b. MOTHER'S MAIDEN NAME <u>ELIZABETH SCOTT</u>			14. NAME OF HUSBAND OR WIFE <u>MYRTLE HOFFMAN</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>499 07 3937</u>		17. INFORMANT Address <u>MYRTLE HOFFMAN 4218 CYPRESS</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>Acute myocardial infarction</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 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.) <u>4201</u>						
20c. TIME OF INJURY Hour _____ a.m. _____ p.m.			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		
21. I attended the deceased from <u>4-21-59</u> , to <u>4-25-59</u> and last saw ^{her} him alive on <u>4-25-59</u> Death occurred at <u>10:25 A M</u> on the date stated above; and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Degree or title) <u>Abraham Gelperin</u>					22b. ADDRESS <u>Gen. Hospital</u>			22c. DATE SIGNED <u>4-27-59</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>		23b. DATE <u>4 28 59</u>		23c. NAME OF CEMETERY OR CREMATORY <u>GLASGOW CEM</u>			23d. LOCATION (City, town, or county) (State) <u>GLASGOW, MO.</u>		
24. FUNERAL DIRECTOR <u>DW Newman's son Mo</u>				ADDRESS <u>K C</u>		25. DATE RECD. BY LOCAL REG. <u>4-28-59</u>		26. REGISTRAR'S SIGNATURE <u>new Marshall</u>	

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

Abraham Gelperin M.D. USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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 *Albert L. Savage*

Licensed Embalmer No. *4812*

P. O. Address *Kansas City, 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.