

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-017858

STATE FILE NUMBER

FILED JUN 9 1959

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 2529

|   |                               |  |  |
|---|-------------------------------|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>JACKSON</u>   |                               | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>MO</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 checked="" type="checkbox"/> No <input type="checkbox"/>  |                               | c. CITY OR TOWN <u>KANSAS CITY</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>                                     |  |
| c. FULL NAME OF (If NOT in hospital, give last name) Length of stay in 1b HOSPITAL OR INSTITUTION <u>DAVEN MANOR, MO 50 YRS</u>   |                               | d. STREET ADDRESS (If outside, give location) <u>4435 TROOST</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>      |  |
| 3. NAME OF DECEASED (Type or print) First <u>ALEX</u> Middle <u>C</u> Last <u>MESHCON</u>   |                               |  | 4. DATE OF DEATH Month <u>5</u> Day <u>20</u> Year <u>1959</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 checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>1876</u>   |
| 9. AGE (In years) <u>82</u> (If birthday) F UNDER 1 YEAR Months Days I UNDER 24 HRS. Hours Min.   |                               | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RESTAURANT OWNER</u>                                      |  |
| 10b. KIND OF BUSINESS OR INDUSTRY   |                               | 11. BIRTHPLACE (City and state or country) <u>GREECE</u>   | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>  |
| 13a. FATHER'S NAME <u>CONSTANDINE MESHCON</u>   |                               | 13b. MOTHER'S MAIDEN NAME <u>unknown</u>   |  |
| 14. NAME OF HUSBAND OR WIFE   |                               | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, <u>No</u> (unknown) (If yes, give war or dates of service))   |  |
| 16. SOCIAL SECURITY NO. <u>unk.</u>   |                               | 17. INFORMANT Address <u>KATINA MITCHELL 4435 TROOST</u>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute Cardiac Failure</u>   |                               |  | INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u>   |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Partial Intestinal Obstruction</u>   |                               |  | <u>3 days</u>  |
| DUE TO (c) <u>Generalized Arteriosclerosis</u>  |                               |  | <u>3 yrs</u>   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>4500</u>   |                               |  | 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.)<br><u>None</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 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>3 April 59</u> to <u>5/20/59</u> and last saw <sup>her</sup> <sub>him</sub> alive on <u>5-19-59</u><br>Death occurred at <u>K.C. Mo.</u> <u>7:00</u> A M on the date stated above; and to the best of my knowledge, from the causes stated. |                               |  |  |
| 22a. SIGNATURE (Degree or title) <u>James W Downey M.D.</u>   |                               | 22b. ADDRESS <u>425 E 63rd KC Mo</u>   |  |
| 22c. DATE SIGNED <u>5-21-59</u>   |                               | 23. NAME OF CEMETERY OR CREMATORY <u>ST. MARY'S CEM</u>  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>   |                               | 23b. DATE <u>5-23-59</u>   |  |
| 23c. LOCATION (City, town, or county) <u>KANSAS CITY, MO</u>  |                               | 23d. (State)   |  |
| 24. FUNERAL DIRECTOR ADDRESS <u>PASSANTINO BROS KCMO</u>  |                               | 25. DATE RECD. BY LOCAL REG. <u>5-21-59</u>  |  |
| 26. REGISTRAR'S SIGNATURE <u>nevar minshall</u>   |                               |  |  |

MEDICAL CERTIFICATION  
James W. Downey USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

Dr Downmy  
425 E 63rd  
Cedar 7000 - 5/20/59

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 *Leonard Passantino* .....

Licensed Embalmer No. 4554 .....

P. O. Address Kemo. .....

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.