Health, Welfare Public Service

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THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-021577
STATE FILE NUMBER

FILED JUL 8 1959

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 2957

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 ☐ No ☐	c. CITY OR TOWN Kansas City — Inside Limits Yes ☐ No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) General Hospital — Length of stay in 1b ←	d. STREET ADDRESS (If outside, give location) 1608½ E. 12th. — Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print)	First: Mary	Middle:	Last: Moss	4. DATE OF DEATH Month 6 Day 11 Year 59
5. SEX 3 Female	6. COLOR OR RACE Negro	7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ 9 DIVORCED ☐	8. DATE OF BIRTH Unknown Age 50	9. AGE (In years last birthday) 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)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Unknown 9	12. CITIZEN OF WHAT COUNTRY? ←	
13a. FATHER'S NAME Unknown	13b. MOTHER'S MAIDEN NAME Unknown	14. NAME OF HUSBAND OR WIFE Unknown		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT None	Address	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Bronchopneumonia due to aspiration of ~~foreign~~ food.

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) substance (tube feeding)

DUE TO (c)

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

Acute brain syndrome 491X

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

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 WORK ☐ NOT WHILE AT WORK ☐

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 6-5-59, to 6-11-59 and last saw her alive on 6-11-59

Death occurred at 12:25 A.M. m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Abraham Gelperin	22b. ADDRESS General Hospital	22c. DATE SIGNED 6-17-59
23a. BURIAL, CREMATION, REMOVAL (Specify) anatomical	23b. DATE K. C. University	23c. NAME OF CEMETERY OR CREMATORY
23d. LOCATION (City, town, or county) (State) Kansas City, Mo.		
24. FUNERAL DIRECTOR Manlove & Willen	ADDRESS 1729 Lyons	25. DATE RECD. BY LOCAL REG. 6-17-59
26. REGISTRAR'S SIGNATURE Neva Minshall		

(Licensed Embalmer's Statement on Reverse Side)

All diseases in Part I must be causally related.

Abraham Gelperin M. D.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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 Maynard Williams

Licensed Embalmer No. 46 S 3

P. O. Address KC

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.