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THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-021630

FILED JUL 8 1959 Registration District No. 149 Primary Registration District No. 1002 STATE FILE NUMBER 2965 Registrar's No.

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Jackson</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kansas City</b>		c. CITY OR TOWN <b>Kansas City</b>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Gen. Hospital</b>		d. STREET ADDRESS <b>2648 Madison</b>	
Length of stay in 1b <b>74 YRS.</b>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Pearl</b> Middle <b>--</b> Last <b>Persinger</b>			4. DATE OF DEATH Month <b>6</b> Day <b>16</b> Year <b>59</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>FEB. 8, 1873</b>
9. AGE (In years by birthday) <b>86</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>	11. BIRTHPLACE (City and state or country) <b>ST. CLAIR Co. Mo.</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S. A.</b>		13. FATHER'S NAME <b>BENJAMIN KIRKPATRICK</b>	
13b. MOTHER'S MAIDEN NAME <b>SEPHRONIA YOUNGER</b>		14. NAME OF HUSBAND OR WIFE <b>ARTHUR PERSINGER</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>----</b>	
17. INFORMANT <b>MARGARET K. CRETCHER</b>		Address <b>8648 MADISON K.C. Mo.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral anoxia due to Cardiac Arrest</b>			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 (e) <b>Bronchopneumonia, Fracture of femoral neck</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT SUICIDE HOMICIDE <input checked="" type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <b>Injured at home</b>	
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____		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 <b>123</b> COUNTY _____ STATE _____	
21. I attended the deceased from <b>6-9-59</b> to <b>6-16-59</b> and last saw her alive on <b>6-16-59</b> Death occurred at <b>8:30 A.M.</b> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <b>Abraham Gelpin M.D.</b>		22b. ADDRESS <b>General Hospital</b>	
22c. DATE SIGNED <b>6/17/59</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>6/18/59</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>FLORAL HILLS CEM.</b>		23d. LOCATION (City, town, or county) (State) <b>KANSAS CITY, MISSOURI</b>	
24. FUNERAL DIRECTOR <b>C. H. BACKMAN &amp; SON I.C. K.C. Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>6-18-59</b>	
26. REGISTRAR'S SIGNATURE <b>neva minshall</b>			

MEDICAL CERTIFICATION - USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Abraham Gelpin, M.D. All areas in Part I must be causally related.

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 *W. P. Quinn* .....

Licensed Embalmer No. *4879* .....

P. O. Address *T. C. 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.