

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-025126

FILED JUL 17 1959

149

Registration District No. _____ Primary Registration District No. 1002 Registrar's No. 3258

3258

STATE FILE NUMBER

DEED

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Resident 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, Mo</u>		Length of stay in 1b <u>40 yrs.</u>		c. CITY OR TOWN <u>Kansas City, Mo</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>General Hospital # 1</u>				d. STREET ADDRESS (If outside, give location) <u>820 Wyandotte</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Thomas</u> Middle <u>Elmer</u> Last <u>Fry</u>				4. DATE OF DEATH Month <u>7-2-</u> Day <u>59</u> Year					
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"/> 2 Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>3-9-1986</u>			
9. AGE (last birthday) <u>72</u>		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HR Hours _____ Min. _____					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Maintenance Man</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Kalis Properties Doe Run, Mo.</u>			11. BIRTHPLACE (City and state or country) <u>Mo.</u>			
12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>			13a. FATHER'S NAME <u>Unknown</u>		13b. MOTHER'S MAIDEN NAME <u>unknown</u>		14. NAME OF HUSBAND OR WIFE <u>Anna C. Fry</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>524-05-2621</u>		17. INFORMANT <u>Carl C. Fry</u>			Address <u>7727 Walnut K.C.</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>Right Hydro-Nephrosis with intra abdominal Hemorrhage</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.							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 (e)					PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown				
19. WAS AUTOPSY PERFORMED? YES <input 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 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>5-3-59</u> to <u>7-2-59</u> and last saw ^{her} him alive on <u>7-2-59</u> Death occurred at <u>1:45</u> <u>P</u> m on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Degree or title) <u>Abraham Galperin</u>				22b. ADDRESS <u>2400 Cherry K.C.MO</u>				22c. DATE SIGNED <u>7-3-59</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>7-3-59</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mc Washington</u>		23d. LOCATION (City, town, or county) (State) <u>Kansas City, Mo.</u>			
24. FUNERAL DIRECTOR <u>Nellody M. Kelley</u>				ADDRESS <u>1001 E. Woodland + Fairwood</u>		25. DATE RECD. BY LOCAL REG. <u>7-3-59</u>		26. REGISTRAR'S SIGNATURE <u>Neva Marshall</u>	

DOCUMENT

MEDICAL CERTIFICATION
Abraham Galperin M.D.

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed George A. Jackson

Licensed Embalmer No. 5059

P. O. Address K.C. Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.