

# DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-025229

FILED VS AUG 1 0 1959 *149*

Registration District No. \_\_\_\_\_

Primary Registration District No. *1002*

Registrar's No. \_\_\_\_\_

3573

STATE FILE NUMBER

<b>1. PLACE OF DEATH</b> a. COUNTY <i>Jackson</i> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>Kansas City</i> Length of stay in 1b <i>56 Yrs.</i> c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>3835 Prospect</i> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <i>Missouri</i> b. COUNTY <i>Jackson</i> c. CITY OR TOWN <i>Kansas City</i> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <i>3835 Prospect</i> Residence on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First <i>Anna</i> Middle <i>Karol</i> Last _____ Date of Death <i>July 22 1959</i>			4. DATE OF DEATH Month <i>July</i> Day <i>22</i> Year <i>1959</i>				
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <i>2/15/85</i>	9. AGE (last birthday) <i>74</i>	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) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>		11. BIRTHPLACE (City and state or country) <i>Lithouania</i>		12. CITIZEN OF WHAT COUNTRY <i>U.S.A.</i>	
13a. FATHER'S NAME (Last) <i>Issac Wolf</i>			13b. MOTHER'S MAIDEN NAME <i>Leah Ishovitch</i>		14. NAME OF HUSBAND OR WIFE <i>Mendel Karol</i>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>No</i>			16. SOCIAL SECURITY NO. <i>-----</i>		17. INFORMANT Address <i>Mendel Karol 3835 Prospect</i>		
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Bronchopneumonia</i> 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 <i>2 weeks</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>Old Atrial Infarction with Right Hemiplegia</i>					PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		
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.)			
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 <i>1947</i> to <i>7/22/59</i> and last saw her <sup>her</sup> <sub>him</sub> alive on <i>7/21/59</i> Death occurred at <i>2 AM</i> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <i>Jack W. Wolf M.D.</i>				22b. ADDRESS <i>409 E. 63 St Kansas City, Mo</i>		22c. DATE SIGNED <i>7/24/59</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>7/23/59</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Sheffield Cemetery</i>		23d. LOCATION (City, town, or county) (State) <i>Kansas City, Missouri</i>	
24. FUNERAL DIRECTOR ADDRESS <i>J.P. Louis Funeral Home. K.C. Mo.</i>				25. DATE RECD. BY LOCAL REG. <i>7-23-59</i>		26. REGISTRAR'S SIGNATURE <i>Gene Marshall</i>	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF *Jack W. Wolf*

AUG 11 1959

**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 Henry Buffington

Licensed Embalmer No. 2754

P. O. Address RCM

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.