

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-025401

STATE FILE NUMBER

3151

FILED JUL 17 1959 Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 3151

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		c. CITY OR TOWN Kansas City	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Menorah Medical Center		d. STREET ADDRESS (If outside, give location) 8247 President Court	
3. NAME OF DECEASED (Type or print) Anna		4. DATE OF DEATH Month 6 Day 25 Year 59	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-21-28
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Secretary		10b. KIND OF BUSINESS OR INDUSTRY Personal	11. BIRTHPLACE (City and state or country) Kansas City, Missouri
13a. FATHER'S NAME Marks Weinstein		13b. MOTHER'S MAIDEN NAME Sarah Rosenberg	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) NO NO		16. SOCIAL SECURITY NO. 492-26-9369	17. INFORMANT Address Esther Rosenberg 8247 President Court
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Brain Tumour, recurrent			INTERVAL BETWEEN ONSET AND DEATH 3 mo.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			
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. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from May 14, 1959 to June 25, 1959 and last saw her alive on June 25, 1959 Death occurred at 11:40 A m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) William J. Mc M. D.		22b. ADDRESS 701 E. 63rd St. K.C. Mo.	
22c. DATE SIGNED 6/27/59			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 6/28/59	
23c. NAME OF CEMETERY OR CREMATORY Sheffield Cemetery		23d. LOCATION (City, town, or county) (State) Kansas City, Missouri	
24. FUNERAL DIRECTOR J.P. Louis Funeral Home. K.C. Mo.		25. DATE RECD. BY LOCAL REG. 6-27-59	
26. REGISTRAR'S SIGNATURE Neva Minshel			

Doctor, coroner, etc., must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION
William J. Mc M. D.

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 *Guy Buffington*
Licensed Embalmer No. *2756*
P. O. Address *K.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.