

IRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-025480

FILED JUL 17 1959

149

Registration District No. \_\_\_\_\_ Primary Registration District No. 1002 Registrar's No. 3230 STATE FILE NUMBER 6

NDED

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Kansas</b> b. COUNTY <b>Wyandotte</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kansas City</b>		Length of stay in 1b <b>3 wks.</b>	c. CITY OR TOWN <b>Kansas City</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Linwood Nursing Home</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>232 N. 31st St.</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <b>Charles Leo Traffis</b>			4. DATE OF DEATH Month Day Year <b>June 30, 1959</b>
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>1-9-93</b>
9. AGE (last birthday) <b>66</b>		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>printer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Bag Co.</b>	11. BIRTHPLACE (City and state or country) <b>Kansas</b>
12. CITIZEN OF WHAT COUNTRY <b>U. S.</b>		13a. FATHER'S NAME <b>John Traffis</b>	
13b. MOTHER'S MAIDEN NAME <b>Madalyn Katz</b>		14. NAME OF HUSBAND OR WIFE <b>Maritta Traffis</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. _____	
17. INFORMANT Address <b>Mrs. Maritta Traffis, K. C. Kans.</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 THROMBOSIS</b> 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 (a) <b>a) RHEUMATOID ARTHRITIS b) HYPERTENSIVE DISEASE</b> 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 INTERVAL BETWEEN ONSET AND DEATH <b>48 hrs.</b>	
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. 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 <b>6/29/59</b> to <b>6/30/59</b> and last saw her alive on <b>6/30/59</b> Death occurred at <b>7:44 PM</b> m on the date stated above, and to the best of my knowledge, from the causes stated.		22a. SIGNATURE (Degree or title) <b>Leo F. Cooper M.D.</b>	
22b. ADDRESS <b>1220 E 31st KC MO</b>		22c. DATE SIGNED <b>7/1/59</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>removal</b>	23b. DATE <b>7-2-59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Highland Park Cem.</b>	23d. LOCATION (City, town, or county) (State) <b>Kansas City, Kansas</b>
24. FUNERAL DIRECTOR <b>R. A. Fulton, Kansas City, Kansas</b>		25. DATE RECD. BY LOCAL REG. <b>7-1-59</b>	26. REGISTRAR'S SIGNATURE <b>Neva Minshall</b>

DOCUMENT

Leo F. Cooper MEDICAL CERTIFICATION

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 Ralph Fulton

Licensed Embalmer No. 383

P. O. Address HCK

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.