

DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS AUG 21 1959

59-029203

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 3877

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence 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</u>		Length of stay in 1b <u>46 Yrs.</u>		c. CITY OR TOWN <u>Kansas City</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>Menorah Medical Center</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>3519 Paseo</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First <u>Edith</u> Middle <u>Mendy</u> Last <u>Mendy</u>				4. DATE OF DEATH Month <u>8</u> Day <u>8</u> Year <u>59</u>									
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>Approx. 3</u>		9. AGE (last birthday) <u>70</u>					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (City and state or country) <u>Ukraine</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		IF UNDER 1 YEAR Months Days Hours Min.					
13a. FATHER'S NAME <u>Moshe Bachus</u>			13b. MOTHER'S MAIDEN NAME <u>Chia</u>			14. NAME OF HUSBAND OR WIFE <u>Sol Mendy</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>NO</u>			16. SOCIAL SECURITY NO. <u>-----</u>		17. INFORMANT Address <u>Sol Mendy 3519 Paseo, K.C.Mo.</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>Ventricular Fibrillation & Cardiac arrest</u> DUE TO (b) <u>Chronic Hypertensive Cardiac disease</u> DUE TO (c) <u>Hypertension</u> 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 (a) <u>Repeated Intestinal obstructions</u>						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 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 Month, Day, Year 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 <u>1947</u> to <u>8-8-59</u> and last saw her/him alive on <u>7PM. of Aug. 7, 1959</u> Death occurred at _____ on the date stated above, and to the best of my knowledge, from the causes stated.				22a. SIGNATURE (Degree or title) <u>M. J. Shypper, M.D.</u>						22b. ADDRESS <u>7516. 63, Kansas City 10, Mo</u>		22c. DATE SIGNED	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>8-9-1959</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mt Carmel Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Kansas City, Missouri</u>							
24. FUNERAL DIRECTOR ADDRESS <u>J.P. Louis Funeral Home, .K.C.Mo</u>				25. DATE RECD. BY LOCAL REG. <u>8-10-59</u>		26. REGISTRAR'S SIGNATURE <u>Neve Marshall</u>							

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF Shypper M. J.

STATEMENT BY LICENSED EMBALMER

JAN 5 1960

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 _____

Greg Buffington

Licensed Embalmer No. 2756

P. O. Address LCM

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.