

DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-029338

FILED VS SEP 1 1959

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 3941 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> 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>6 Mon.</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>General Hospital</u>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>817 E. 31st.</u>	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print)	First <u>Mary</u>	Middle <u>Frances</u>	Last <u>Thomas</u>	4. DATE OF DEATH	Month <u>8</u>	Day <u>12</u>	Year <u>59</u>
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5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>June 5 1883</u>	9. AGE (last birthday) <u>76</u>	IF UNDER 1 YEAR Months	IF UNDER 24 HR Days	Hours	Min.
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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>home Jack Mo.</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S. A.</u>
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13a. FATHER'S NAME <u>James P. Bynum</u>	13b. MOTHER'S MAIDEN NAME <u>Jennie Thompson</u>	14. NAME OF HUSBAND OR WIFE <u>Wm G. Bynum Dec.</u>
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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>494-30-0241</u>	17. INFORMANT <u>Aline Mitchell, Lee's Summit Mo</u>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:	INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>Cerebral Vascular Thrombosis</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	
DUE TO (b) <u>Arteriosclerotic Heart Disease</u>	
DUE TO (c)	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)	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
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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.)
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m. _____	Month, Day, Year
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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
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21. I attended the deceased from 8-7-59 to 8-12-59 and last saw ~~her~~ ^{him} alive on 8-12-59
Death occurred at 7:18 P.M. 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</u>	22c. DATE SIGNED <u>8.13.59</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>Aug. 15-1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Home Jack Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Home Jack Mo.</u>
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24. FUNERAL DIRECTOR <u>LANGSFORD FUNERAL Home</u>	ADDRESS <u>Lee's Summit Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>8.13.59</u>	26. REGISTRAR'S SIGNATURE <u>Neva Trinchell</u>
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DOCUMENT

BY AFFIDAVIT OF Abraham Galperin, Medical Certification

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 N. B. Langston

Licensed Embalmer No. 1490

P. O. Address Lee's

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