RI DIVISION OF HEALTH — STANDARD CERTIFICATE OF DEATH

FILED VS SEP 25 1959

59-032288

STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4452

1. PLACE OF DEATH
a. COUNTY Jackson
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City
Length of stay in 1b 1 yr.
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION General Hospital
Inside Limits Yes ☐ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY Jackson
c. CITY OR TOWN Kansas City
Inside Limits Yes ☐ No ☐
d. STREET ADDRESS (If outside, give location) 1905 Agnes
Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print) First: Jeffrey Middle: Last: Cruse
4. DATE OF DEATH Month Day Year: 9-13-59
5. SEX: Male
6. COLOR OR RACE: Negro
7. Married ☐ Never Married ☑ Widowed ☐ Divorced ☐
8. DATE OF BIRTH: 6-16-58
9. AGE (last birthday): 1
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)
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (City and state or country): St Joseph Mo
12. CITIZEN OF WHAT COUNTRY: U S A
13a. FATHER'S NAME: Byron Cruse
13b. MOTHER'S MAIDEN NAME: Lawra Hoard
14. NAME OF HUSBAND OR WIFE: —
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: —
17. INFORMANT Address: Byron Cruse I905 Agnes

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Poliomyelitis, Bulbar
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b)
DUE TO (c)
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)
PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
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 ☐ NOT WHILE AT WORK ☐
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 9-12-59 to 9-13-59 and last saw him alive on 9-13-59
Death occurred at 4:55 P m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Abraham Gelperin (Degree or title) M.D.
22b. ADDRESS 2400 Cherry
22c. DATE SIGNED 9-13-59

23a. BURIAL, CREMATION, REMOVAL (Specify) Buriel
23b. DATE 9/I6/59
23c. NAME OF CEMETERY OR CREMATORY —
23d. LOCATION (City, town, or county) (State) St Joseph Mo

24. FUNERAL DIRECTOR ADDRESS: Manlove6Williams I729 Lydia
25. DATE RECD. BY LOCAL REG.: 9-14-59
26. REGISTRAR'S SIGNATURE: Neva Minshall

(Licensed Embalmer's Statement on Reverse Side)

BY AFFIDAVIT OF Abraham Gelperin M.D. MEDICAL CERTIFICATION

DOCUMENT

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 Maynard William

Licensed Embalmer No. 46 5-3

P. O. Address K C. Mo

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