

FILED VS OCT 16 1959

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-036052

Registration District No. 149 Primary Registration District No. 1002 STATE FILE NUMBER Registrar's No. 4680

V. S. 300  
Rev. 1-57

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Jackson</b>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kansas City</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	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>4618 Warwick</b>		Length of stay in lb <b>65 Years</b>	d. STREET ADDRESS (If outside, give location) <b>4618 Warwick</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>NETTIE BOLT ALTMAN</b>			4. DATE OF DEATH Month <b>September</b> Day <b>27</b> Year <b>1959</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Cauc.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 3, 1868</b>	9. AGE (In years last birthday) <b>91</b>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (City and state or country) <b>Peoria, Illinois</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13a. FATHER'S NAME <b>Benjamin Bolt</b>		13b. MOTHER'S MAIDEN NAME <b>Elizabeth Smith</b>	
14. NAME OF HUSBAND OR WIFE <b>Frank G. Altman Sr. (Deceased)</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Frank G. Altman, 1025 W. 53rd Terr. K.C.Mo.</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>Arterio sclerotic heart disease</b>		INTERVAL BETWEEN ONSET AND DEATH <b>5 years</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>H200</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 _____ 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 <b>11 November 1954</b> to <b>27 September 59</b> and last saw her/him alive on <b>27 Sept 1959</b> Death occurred at <b>11:40 AM</b> m on the date stated above; and to the best of my knowledge, from the cause stated.					
22a. SIGNATURE (Degree or title) <i>Blaine Z. Hibbard M.D.</i>			22b. ADDRESS <b>411 Nichols Rd KCMo</b>		22c. DATE SIGNED <b>28 Sept 59</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>Sept. 29, 1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mt. St. Marys Cemetery</b>		23d. LOCATION (City, town, or county) <b>Kansas City, Mo.</b>
24. FUNERAL DIRECTOR <b>Muehlebach</b>		ADDRESS <b>6800 Troost</b>		25. DATE RECD. BY LOCAL REG. <b>9-28-59</b>	26. REGISTRAR'S SIGNATURE <i>Neva Minshall</i>

securing the medical certification in the specific manner required by 193.140 MoRS 1949. 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.

Blaine Z. Hibbard USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

13 Co. 2nd Lt. Richard - 209  
411 Richard Rd.  
1:30 P.M.

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 R. E. Nichols .....

Licensed Embalmer No. 4994 .....

P. O. Address H. E. Nichols .....

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.