

FEDERAL BUREAU OF INVESTIGATION
FURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-036078

FILED VS. NOV 2 1959

149

Primary Registration District No. **1002**

Registrar's No. **4967**

4967

STATE FILE NUMBER

ENDED

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Jackson	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City		Length of stay in 1b 48 yrs.	c. CITY OR TOWN Kansas City Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 1510 Drury		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 1510 Drury Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Dora Middle Alice Last Blank			4. DATE OF DEATH Month 10 Day 15 Year 1959	
5. SEX Female	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH Sept. 20-1884	9. AGE (last birthday) 75
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (City and state or country) Ozark, Mo.	12. CITIZEN OF WHAT COUNTRY U.S.A.

13a. FATHER'S NAME Frank Bolain		13b. MOTHER'S MAIDEN NAME Martha Crain		14. NAME OF HUSBAND OR WIFE James M. Blank	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 487-16-5577A		17. INFORMANT Mrs. Helen Wilke Address 3633 Bayfield N.C. 7th	

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) Coronary Occlusion			Sudden
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Coronary Insufficiency		1 yr. ago.
	DUE TO (c) Arteriosclerotic Heart Disease		2 yrs. ago.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Branchiectosis & Pneumonia			PART III. If deceased was female, was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" 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 **3-12-58** to **10-13-59** and last saw her **live** on **10-13-59**
 Death occurred at **4:30** **P.** m on the date stated above, and to the best of my knowledge, from the causes stated.

22. SIGNATURE (Degree or title) D. Frederick A. Treffer M.D.		22b. ADDRESS 5518 Truman Rd. K.C. Mo.		22c. DATE SIGNED 10-15-59	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 10-17-59	23c. NAME OF CEMETERY OR CREMATORY Green Lawn Cem.		23d. LOCATION (City, town, or county) (State) Kansas City Mo.	
24. FUNERAL DIRECTOR C.H. Blackburn ADDRESS Son M. K.C. Mo.		25. DATE RECD. BY LOCAL REG. 10-16-59		26. REGISTRAR'S SIGNATURE Neva Minshall	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

Frederick A. Treffer

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

Wayne Smith

Licensed Embalmer No. 5081

P. O. Address H. C. Ma.

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.