

URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH
 FILED VS NOV 2 1959

59-036364
 STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 5063

RECEIVED

1. PLACE OF DEATH a. COUNTY JACKSON		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY JACKSON	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN KANSAS CITY MO.		c. CITY OR TOWN KANSAS CITY 24 MO	
Length of stay in 1b 54 YRS.		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION ST. LUKE'S HOSPITAL		d. STREET ADDRESS (if outside, give location) 5220 E 7th ST.	
Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First MIDDLE Last ELEANOR LUCILLE REPASS			4. DATE OF DEATH Month, Day Year OCT. 18 1959		
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH APRIL 4, 1905	9. AGE (last birthday) 54	IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BOOKKEEPER		10b. KIND OF BUSINESS OR INDUSTRY MONTGOMERY WARD		11. BIRTHPLACE (City and state or country) K.E. Mo.	
12. CITIZEN OF WHAT COUNTRY U.S.		13a. FATHER'S NAME OSCAR CRONE		13b. MOTHER'S MAIDEN NAME ADENE SMITH	
14. NAME OF HUSBAND OR WIFE HAROLD B. REPASS		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 496-26-5646	
17. INFORMANT Harold REPASS		Address 5220 E 7th ST.			

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) Bronchopneumonia			
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Carcinomatous			
DUE TO (c) Reticular Cell Sarcoma			
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	

19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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 July '59 to 10-18-59 and last saw her alive on 10-18-59
 Death occurred at 3:50 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) K. Skellman M.D.		22b. ADDRESS 4635 Wyandotte K.C. Mo.		22c. DATE SIGNED 10-19-59	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE OCT. 21, 1959	23c. NAME OF CEMETERY OR CREMATORY Mt. Washington Cem.		23d. LOCATION (City, town, or county) KANSAS CITY, Mo.	
24. FUNERAL DIRECTOR ADDRESS STATES FUNERAL HOME K.E. KANS.		25. DATE RECD. BY LOCAL REG. 10-21-59		26. REGISTRAR'S SIGNATURE M. W. Marshall	

DOCUMENT MEDICAL CERTIFICATION BY AFFIDAVIT OF SKILLMAN

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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 Murray Wilson

Licensed Embalmer No. 4989

P. O. Address Parkville

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.

Dr. Bygro - 4635 Wym.