URI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

59–039922

STATE FILE NUMBER

FILED VS DEC 10 1959

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 5245

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: 22 Yrs.
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: Menorah Med. Center
Inside Limits: Yes XXX 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 XX No ☐
d. STREET ADDRESS (If outside, give location): 53 East 32nd. St.
Reside on Farm: Yes ☐ No XXX

3. NAME OF DECEASED (Type or print): First: Ethel Middle: Belle Last: Berkowitz
4. DATE OF DEATH: Month: Oct. Day: 30 Year: 1959
5. SEX: Female
6. COLOR OR RACE: White
7. Married XX Never Married ☐ Widowed ☐ Divorced ☐
8. DATE OF BIRTH: 2-12-03
9. AGE (last birthday): 56
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): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (City and state or country): Ashburn, Mo.
12. CITIZEN OF WHAT COUNTRY: U.S.A.
13a. FATHER'S NAME: HOMER L. WILSON
13b. MOTHER'S MAIDEN NAME: MARY ELIZABETH NEAL
14. NAME OF HUSBAND OR WIFE: TULE M. BERKOWITZ
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.: UNKNOWN
17. INFORMANT: TULE M. BERKOWITZ Address: 53 E.32 STREET

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pulmonary Edema
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): Right Heart Failure
DUE TO (c): Cor Pulmonale
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 10-25-59, to 10-30-59 and last saw her alive on 10-30-59
Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.
22a. SIGNATURE: David Wolfman (Degree or title) MD
22b. ADDRESS: 4840 Prospect
22c. DATE SIGNED: 10-31-59

BY AFFIDAVIT OF David Waxman

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE: NOV 2, 1959
23c. NAME OF CEMETERY OR CREMATORY: FLORAL HILLS CEM
23d. LOCATION (City, town, or county) (State): KANSAS CITY MO.
24. FUNERAL DIRECTOR ADDRESS: D.W. Newcomers Sons Kansas City, Mo.
25. DATE RECD. BY LOCAL REG.: 11-2-59
26. REGISTRAR'S SIGNATURE: Neva Marshall

(Licensed Embalmer's Statement on Reverse Side)

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 m

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____ Signed Norman W. Larson

Signature of Student Embalmer

Licensed Embalmer No. 4889

P. O. Address H.C., Mo.

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