

MURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-040215

FILED VS DEC 10 1959

STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 5478

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|---|--|---|--|
| 1. PLACE OF DEATH | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) | |
| a. COUNTY <u>JACKSON</u> | b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>KANSAS CITY</u> | a. STATE <u>Missouri</u> | b. COUNTY <u>JACKSON</u> |
| Length of stay in 1b <u>10 YRS.</u> | | c. CITY OR TOWN <u>KANSAS CITY</u> | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>OSTEOPATHIC HOSPITAL</u> | | d. STREET ADDRESS (If outside, give location) <u>143 S. WHITE</u> | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |

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|---|-------------------------------|--|--|---|
| 3. NAME OF DECEASED (Type or print) | | | 4. DATE OF DEATH | |
| First <u>JOSEPH</u> | Middle <u>E.</u> | Last <u>MAIER</u> | Month <u>11</u> | Day <u>12</u> Year <u>59</u> |
| 5. SEX <u>MALE</u> | 6. COLOR OR RACE <u>WHITE</u> | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/> | 8. DATE OF BIRTH <u>12-19-1898</u> | 9. AGE (last birthday) <u>60</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HELPING HAND</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>HELPING HAND</u> | 11. BIRTHPLACE (City and state or country) <u>new york</u> | 12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u> |

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|--|---|---|
| 13a. FATHER'S NAME <u>JOSEPH MAIER</u> | 13b. MOTHER'S MAIDEN NAME <u>ADALIDE NOWE</u> | 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) <u>NO</u> | 16. SOCIAL SECURITY NO. <u>066-18-0603</u> | 17. INFORMANT <u>ALBERT MAIER</u> Address <u>143 S. WHITE</u> |

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|---|---|---|
| 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) | <u>chronic circulatory failure</u> | <u>months</u> |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | DUE TO (b) <u>Pan Valvular disease with adhesive pericarditis</u> | <u>years</u> |
| | DUE TO (c) <u>old Rheumatic state</u> | <u>years</u> |
| 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. |
| <u>Postul Carcinoma and pleural effusion</u> | | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |

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| 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 <u>5:27 a.</u> Month, Day, Year <u>11/10/59</u> | |

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|--|--|---|--------|-------|
| 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 <u>11/10/59</u> to <u>11/12/59</u> and last saw <u>him</u> alive on <u>11/12/59</u> | | Death occurred at <u>5:27 a.</u> on the date stated above, and to the best of my knowledge, from the causes stated. | | |

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| 22a. SIGNATURE (Degree or title) <u>Milton S. Steinberg P.O.</u> | 22b. ADDRESS <u>926 E. 11th St. K.C. Mo.</u> | 22c. DATE SIGNED <u>11/13/59</u> |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE <u>11/16/59</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Mc. Washington</u> |
| 24. FUNERAL DIRECTOR <u>Sheil Funerals Home K.S. Mo.</u> | 25. DATE RECD. BY LOCAL REG. <u>11-13-59</u> | 26. REGISTRAR'S SIGNATURE <u>Neva Minshall</u> |

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT BY AFFIDAVIT OF S. Steinberg MEDICAL CERTIFICATION

AUG 9 1962

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 Harold D. Reich

Licensed Embalmer No. 4998

P. O. Address Kansas City

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).²

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.