

URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-040301

FILED VS. NOV 3 0 1959 149

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

5317

STATE FILE NUMBER

UNDECEASED

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		Length of stay in 1b 50yrs.	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 5101 Highland		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 5101 Highland Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First MARTHA Middle HALBHUBER Last PHILLIPS			4. DATE OF DEATH Month Nov. Day 3 Year 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 6-1-1893	9. AGE (last birthday) 66	IF UNDER 1 YEAR Months Days 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 Home	11. BIRTHPLACE (City and state or country) Austria	12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME Adolph Schultz		13b. MOTHER'S MAIDEN NAME Marie Franke	14. NAME OF HUSBAND OR WIFE Frank		
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. None	17. INFORMANT Address Helen R. Colley - 246 E. 73 Terr.		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARINOMA of the Gall bladder with LIVER METASTASIS		INTERVAL BETWEEN ONSET AND DEATH 4 months
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)		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	
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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 _____ a.m. _____ p.m. Month, Day, Year _____			

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 Kansas City, Mo.	COUNTY _____ STATE _____
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21. I attended the deceased from **July 13, 1959** to **Nov. 3, 1959** and last saw ^{her} him alive on **Nov. 2, 1959**
Death occurred at **6:20PM** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Joy J. Carduff, M.D. MD (Degree or title)	22b. ADDRESS 5830 Nall - Mission, Kansas	22c. DATE SIGNED 11-4-59
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23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 11-6-59	23c. NAME OF CEMETERY OR CREMATORY Galvany Cemetery	23d. LOCATION (City, town, or county) Kansas City, Mo. (State)
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24. FUNERAL DIRECTOR Melody-McGilley-Eylar ADDRESS 1800 Linwood	25. DATE RECD. BY LOCAL REG. 11-4-59	26. REGISTRAR'S SIGNATURE Jewell Marshall
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(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF Carduff

D. J. J. Carduff
5830 Wall
He 2-448
Now till 5

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____
or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed *George A. Jack*

Licensed Embalmer No. 505

P. O. Address 1927

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