

UNIVERSITY DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS. JAN 19 1960 149 Registration District No. 1002 Registrar's No. 6264 -59-046754 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Jackson</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kansas City</b>		Length of stay in 1b →	c. CITY OR TOWN <b>Kansas City</b> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Menorah Medical Center</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>1625 E. 7th Street</b> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>Floyd</b> Middle <b>E.</b> Last <b>Glover</b>			4. DATE OF DEATH Month <b>12</b> Day <b>29</b> Year <b>59</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>9-12-1908</b>	9. AGE (last birthday) <b>51</b>	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Proof Reader</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Tension Envelope Co. Springfield, Mo.</b>		11. BIRTHPLACE (City and state or country) <b>USA</b>		
13a. FATHER'S NAME <b>Ernest F. Glover</b>		13b. MOTHER'S MAIDEN NAME ---		14. NAME OF HUSBAND OR WIFE <b>Virginia Glover</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>496-05-1873</b>	17. INFORMANT Address <b>Virginia Glover- 4625 E. 7th St.-</b>			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a) **Carcinomatosis - primary site unilateral**  
DUE TO (b) \_\_\_\_\_  
DUE TO (c) \_\_\_\_\_  
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) **Chronic pyelonephritis, Nephrothiasis**  
PART III. If deceased was female was there a pregnancy in last 90 days.  
 Yes  No  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 _____ 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 <b>Kansas City, Jackson, Missouri</b>	COUNTY <b>Jackson</b>	STATE <b>Missouri</b>
21. I attended the deceased from <b>July 19 59</b> to <b>Dec. 29, 1959</b> and last saw her/him live on <b>Dec. 29, 1959</b> Death occurred at <b>4:30 pm</b> on the date stated above, and to the best of my knowledge, from the causes stated.				

22a. SIGNATURE (Degree & title) <b>Walter Harvey Jacobs, M.D.</b>		22b. ADDRESS <b>751-E. 63rd St., H.G. 10, Mo.</b>		22c. DATE SIGNED <b>12/30/59</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>12-31-59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mount Moriah</b>	23d. LOCATION (City, town, or county) <b>Kansas City, Missouri</b>	
24. FUNERAL DIRECTOR <b>Earp and Sons-Kansas City, Missouri</b>		25. DATE RECD. BY LOCAL REG. <b>12-30-59</b>	26. REGISTRAR'S SIGNATURE <b>Neva Marshall</b>	

DOCUMENT BY AFFIDAVIT OF Walter Harvey Jacobs M.D. MEDICAL CERTIFICATION

**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

*John B. Poy*

Licensed Embalmer No.

295-58

P. O. Address

H. C. P.

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.