

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-006200

FILED VS FEB 23 1960

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 764 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. <u>Missouri</u> b. COUNTY <u>Jackson</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kansas City</u>		Length of stay in 1b <u>57 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>General Hospital #1</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>3012 Charlotte</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Jacob</u> Middle <u>Cohen</u> Last <u>Cohen</u>			4. DATE OF DEATH Month <u>2</u> Day <u>8</u> Year <u>60</u>				
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (last birthday) <u>Approx. 79</u>	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HR Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Shoemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Shoe</u>		11. BIRTHPLACE (City and state or country) <u>Poland</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Joseph Cohen</u>		13b. MOTHER'S MAIDEN NAME <u>Sarah</u>		14. NAME OF HUSBAND OR WIFE <u>Ida Cohen</u>			
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> </u>		17. INFORMANT Address <u>Ida Cohen 3012 Charlotte K.C.Mo.</u>			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Aspiration pneumonia</u>		INTERVAL BETWEEN ONSET AND DEATH
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 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 <u> </u> a.m. <u> </u> p.m.	Month, Day, Year <u> </u> <u> </u> <u> </u>		

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 <u> </u> COUNTY <u> </u> STATE <u> </u>	
21: I attended the deceased from <u>1-31-1960</u> to <u>2-8-1960</u> and last saw <u>xx</u> him alive on <u>2-8-60</u> Death occurred at <u>6:30</u> P.m. on the date stated above, and to the best of my knowledge, from the causes stated.			

22a. SIGNATURE <u>Al Dwyer</u> (Degree or title) <u>M.D.</u>		22b. ADDRESS <u>2400 Cherry -City</u>		22c. DATE SIGNED <u>2-9-60</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>2/10/1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>MtCarmel Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Kansas City, Missouri</u>	
24. FUNERAL DIRECTOR <u>J.P. Louis</u> ADDRESS <u>Funeral Home K.C., MO.</u>		25. DATE RECD. BY LOCAL REG. <u>2-9-60</u>		26. REGISTRAR'S SIGNATURE <u>Neve Winchall</u>	

DOCUMENT
MEDICAL CERTIFICATION
BY AFFIDAVIT OF Dwyer

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 Henry Buffington

Licensed Embalmer No. 2750

P. O. Address 1000

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.