

**FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**FILED VS MAR 28 1960**

**60-010807**

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 1479 STATE FILE NUMBER

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| 1. PLACE OF DEATH<br>a. COUNTY <b>Jackson</b>  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Missouri</b> b. COUNTY <b>Jackson</b> |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <b>Kansas City, Missouri</b>            |  | Length of stay in lb <b>75 years</b>   | c. CITY OR TOWN <b>Kansas City</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>                                 |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <b>Menorah Medical Center</b> |  | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  | d. STREET ADDRESS (If outside, give location) <b>1021 Linwood</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |

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| 3. NAME OF DECEASED (Type or print)<br>First <b>Arthur</b> Middle <b>C.</b> Last <b>Block</b> | 4. DATE OF DEATH<br>Month <b>3</b> Day <b>10</b> Year <b>60</b> |
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|                    |                               |   |                                  |                                  |                                |                              |
|--------------------|-------------------------------|---|----------------------------------|----------------------------------|--------------------------------|------------------------------|
| 5. SEX <b>Male</b> | 6. COLOR OR RACE <b>White</b> | 7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/><br>Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH <b>10-30-82</b> | 9. AGE (last birthday) <b>77</b> | IF UNDER 1 YEAR<br>Months Days | IF UNDER 24 HR<br>Hours Min. |
|--------------------|-------------------------------|---|----------------------------------|----------------------------------|--------------------------------|------------------------------|

|   |                                   |   |  |
|---|-----------------------------------|---|--|
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mig'r Representative</b> | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (City and state or country) <b>Las Vegas, New Mex.</b> | 12. CITIZEN OF WHAT COUNTRY <b>USA</b> |
|---|-----------------------------------|---|--|

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|---------------------------------------|--|---------------------------------------|
| 13a. FATHER'S NAME <b>Isaac Block</b> | 13b. MOTHER'S MAIDEN NAME <b>Flora Foreman</b> | 14. NAME OF HUSBAND OR WIFE <b>XX</b> |
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| 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>496-16-3758A</b> | 17. INFORMANT Address <b>Mrs. Lucyle Wetzel, San Diego, Cal.</b> |
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| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> |  | INTERVAL BETWEEN ONSET AND DEATH <b>immediate</b> |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.   | DUE TO (b) <b>Coronary Atherosclerosis</b> |   |
|  | DUE TO (c)                                 |   |

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| 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.<br><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.) |
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| 20c. TIME OF INJURY<br>Hour Month, Day, Year<br>a.m. p.m. |
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|   |  |   |
|---|--|---|
| 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" 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 1955 to 3-10-1960 and last saw her/him alive on 3-10-60  
Death occurred at 9:30 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

|  |                                |                                 |
|--|--------------------------------|---------------------------------|
| 22a. SIGNATURE (Degree or title) <b>William Louis Mundy M.D.</b> | 22b. ADDRESS <b>1103 Grand</b> | 22c. DATE SIGNED <b>3-11-60</b> |
|--|--------------------------------|---------------------------------|

|   |                          |  |  |
|---|--------------------------|--|--|
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b> | 23b. DATE <b>3-13-60</b> | 23c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b> | 23d. LOCATION (City, town, or county) (State) <b>Kansas City Mo.</b> |
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| 24. FUNERAL DIRECTOR ADDRESS <b>Wagner Funeral Home, K.C. Mo.</b> | 25. DATE RECD. BY LOCAL REG. <b>3-12-60</b> | 26. REGISTRAR'S SIGNATURE <b>Irene Minshall</b> |
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DOCUMENT

William Lowe Mundy Medical Certification

BY AFFIDAVIT OF

**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 Alvin R. Haccus

Licensed Embalmer No. 415

P. O. Address H. E.

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.