JRI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

-60-015521

STATE FILE NUMBER

FILED VS MAY 16 1960 149 Registration District No. 1002 Registrar's No. 2426

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1. PLACE OF DEATH a. COUNTY: Jackson	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Missouri b. COUNTY: Jackson
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: Kansas City, Missouri — Length of stay in 1b: 25 yrs.	c. CITY OR TOWN: Kansas City — Inside Limits: Yes ☒ No ☐
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: Menorah Medical Center — Inside Limits: Yes ☒ No ☐	d. STREET ADDRESS (If outside, give location): 1044 E. 4th — Reside on Farm: Yes ☐ No ☒

3. NAME OF DECEASED (Type or print)	First: MINNIE	Middle:	Last: MOORE	4. DATE OF DEATH	Month: APRIL 29 Day: 1960 Year:
5. SEX: Female	6. COLOR OR RACE: White	7. Married ☐ Never Married ☐ Widowed ☒ Divorced ☐	8. DATE OF BIRTH: 3-10-86	9. AGE (last birthday): 74 yrs.	IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HR: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Nurse	10b. KIND OF BUSINESS OR INDUSTRY: Nursing	11. BIRTHPLACE (City and state or country): Omaha, Nebraska	12. CITIZEN OF WHAT COUNTRY: U. S. A.		
13a. FATHER'S NAME: Joseph Sporal	13b. MOTHER'S MAIDEN NAME: Unknown	14. NAME OF HUSBAND OR WIFE: Daniel Moore (dec)			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): None	16. SOCIAL SECURITY NO.: 492-18-7220	17. INFORMANT: Chauncey Gamm (son) Address: 4107 W. 73rd 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): Cerebro-Vascular accident — INTERVAL BETWEEN ONSET AND DEATH: 8 days

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b): Hypertension > Arteriosclerosis — unknown

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): Carcinoma, right breast

PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☒ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

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 ☐ NOT WHILE AT WORK ☐

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 4/22/60, to 4/29/60 and last saw her/him alive on 4/28/60

Death occurred at 2 15 AM m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): Alexander Shifrin M.D.	22b. ADDRESS: 701 East 63rd, K.C. 10, Mo.	22c. DATE SIGNED: 4/30/60	
23a. BURIAL, CREMATION, REMOVAL (Specify): Removal	23b. DATE: May 3. 1960	23c. NAME OF CEMETERY OR CREMATORY: Leavenworth Nat. Cemetery	23d. LOCATION (City, town, or county) (State): Leavenworth Kansas
24. FUNERAL DIRECTOR: Muehlebach Funeral Home	ADDRESS: 6800 Troost	25. DATE RECD. BY LOCAL REG.: 5-2-60	26. REGISTRAR'S SIGNATURE: Neva Minshall

(Licensed Embalmer's Statement on Reverse Side)

BY AFFIDAVIT OF Alexander Shifrin MEDICAL CERTIFICATION DOCUMENT

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 J. T. Crowell

Licensed Embalmer No. 490

P. O. Address K. C. Mo

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