

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-019363

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STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 2528

INDEXED

DOCUMENT

HARRY K. COHEN, M.D. MEDICAL CERTIFICATION

BY AFFIDAVIT OF

|  |   |   |  |  |  |  |
|--|---|---|--|--|--|--|
| 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</b>  |   | Length of stay in 1b  | c. CITY OR TOWN <b>KANSAS CITY</b>   |  | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |  |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <b>6804 ROCKHILL ROAD</b>   |   |   | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>   | d. STREET ADDRESS (If outside, give location)<br><b>6804 ROCKHILL ROAD</b> |  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Joy</b> Middle <b>Bruce</b> Last <b>DOLSON</b>   |   |   | 4. DATE OF DEATH<br>Month <b>MAY</b> Day <b>5</b> Year <b>1960</b>   |  |  |  |
| 5. SEX<br><b>MALE</b>  | 6. COLOR OR RACE<br><b>CAUCASIAN</b>  | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>MAR 18 1924</b>   | 9. AGE (last birthday)<br><b>66</b>  | IF UNDER 1 YEAR<br>Months Days Hours Min.  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>ENGINEER</b>   |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>U.S. GOVT ENGINEER</b>  |  | 11. BIRTHPLACE (City and state or country)<br><b>BAY CITY, MICHIGAN</b>    |  |  |
| 12. CITIZEN OF WHAT COUNTRY<br><b>USA</b>  |   | 13a. FATHER'S NAME<br><b>BRUCE DOLSON</b>   |  | 13b. MOTHER'S MAIDEN NAME<br><b>SARAH JAY</b>                              |  |  |
| 14. NAME OF HUSBAND OR WIFE<br><b>GERTRUDE DOLSON</b>  |   | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>NO</b>                                       |  |  |  |  |
| 16. SOCIAL SECURITY NO.<br><b>486-10-7795</b>  |   | 17. INFORMANT<br>Address<br><b>MRS GERTRUDE DOLSON 6804 ROCKHILL RD</b>   |  |  |  |  |
| 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 occlusion</b><br>DUE TO (b) <b>Arteriosclerotic Cardiovascular disease</b><br>DUE TO (c) _____<br>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)<br>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 |   |   |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>1 day</b>                                     |  |
| 19. WAS AUTOPSY PERFORMED?<br>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<br>Hour _____<br>a.m. _____<br>p.m. _____  | 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<br>COUNTY _____ STATE _____                             |  |
| 21. I attended the deceased from <b>1944</b> to <b>May 5, 1960</b> and last saw him alive on <b>May 5, 1960</b><br>Death occurred at <b>5:30 P.</b> on the date stated above, and to the best of my knowledge from the causes stated.  |   |   |  |  |  |  |
| 22a. SIGNATURE<br><b>Harry K. Cohen M.D.</b>   |   |   | 22b. ADDRESS<br><b>751 E. 634 St.</b>  |  | 22c. DATE SIGNED<br><b>5/5/60</b>  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>   |   | 23b. DATE<br><b>7 MAY 1960</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>CALVARY CEMETERY</b>  |  | 23d. LOCATION (City, town, or county) (State)<br><b>KANSAS CITY MO</b>               |  |
| 24. FUNERAL DIRECTOR<br><b>MEINLEBACH</b>  |   | ADDRESS<br><b>6800 TROOST</b>   |  | 25. DATE RECD. BY LOCAL REG.<br><b>5-7-1960</b>                            | 26. REGISTRAR'S SIGNATURE<br><b>Teva Minshall</b>                                    |  |

**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 David C. King

Licensed Embalmer No. 4934

P. O. Address Mo 14, Mo.

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.