

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-026992

FILED VS AUG 8 1960

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 3701 STATE FILE NUMBER

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		Length of stay in lb 73 YEARS	c. CITY OR TOWN KANSAS CITY Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 5900 SWOPE PARKWAY SWOPE RIDGE NURSING HOME		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 229 WARD PARKWAY Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last BEATRICE LIEBERMAN			4. DATE OF DEATH Month Day Year JULY 15 1960			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH OCT. 18, 1877	9. AGE (last birthday) 82	IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) AT HOME		10b. KIND OF BUSINESS OR INDUSTRY -----	11. BIRTHPLACE (City and state or country) ST. LOUIS, MISSOURI		12. CITIZEN OF WHAT COUNTRY U. S. A.	
13a. FATHER'S NAME MAX CHARLES REEFER		13b. MOTHER'S MAIDEN NAME MARIE COHEN		14. NAME OF HUSBAND <i>or wife</i> DR. B. ALBERT LIEBERMAN, SR.		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. NONE	17. INFORMANT Address DR. B. ALBERT LIEBERMAN, JR. KANSAS CITY, MO. 424 WEST 70TH			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage in Right Hemisphere		INTERVAL BETWEEN ONSET AND DEATH 10 days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.)	DUE TO (b) Cerebral Arteriosclerosis 1 year	
	DUE TO (c)	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Arteriosclerotic Heart Disease		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" 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 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	COUNTY	STATE
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21. I attended the deceased from June 20, 1960 to July 15, 1960 and last saw her alive on July 14, 1960
Death occurred at 6:30 A. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Jack W. Wolf M.D.	22b. ADDRESS 409 E. 63 St. Kansas City, Mo.	22c. DATE SIGNED 7/15/60
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23a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION	23b. DATE JULY 15, 1960	23c. NAME OF FUNERAL HOME OR CREMATORY D.W. NEWCOMER'S SONS	23d. LOCATION (City, town, or county) (State) KANSAS CITY MISSOURI
24. FUNERAL DIRECTOR D. W. NEWCOMER'S SONS 1331 BRUSH CREEK		25. DATE RECD. BY LOCAL REG. 7-16-60	26. REGISTRAR'S SIGNATURE Neva Marshall

DOCUMENT
MEDICAL CERTIFICATION
BY AFFIDAVIT OF JACK W. WOLF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was ^{NOT}embalmed by
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed _____

Licensed Embalmer No. _____

P. O. Address _____

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.