

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-030636

FILED VS. SEP 12 1960

149

Registration District No. 1002 Registrar's No. 4425

STATE FILE NUMBER

DEED

1. PLACE OF DEATH a. COUNTY <b>JACKSON</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>JACKSON</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>KANSAS CITY</b>		Length of stay in lb <b>45YRS</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) HOSPITAL OR INSTITUTION <b>MENORAH</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>5409 Euclid</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>FRED</b> Middle <b>WM</b> Last <b>KRAUSE</b>			4. DATE OF DEATH Month <b>8</b> Day <b>27</b> Year <b>1960</b>			
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>3-30-1898</b>	9. AGE (last birthday) <b>62</b>	IF UNDER 1 YEAR Months <b>6</b> Days <b>2</b>	IF UNDER 24 HR Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>WELDER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>mfg.</b>		11. BIRTHPLACE (City and state or country) <b>CLARKSFORK MO.</b>	12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	

13a. FATHER'S NAME <b>August KRAUSE</b>	13b. MOTHER'S MAIDEN NAME <b>Pauline SEIFERT</b>	14. NAME OF HUSBAND OR WIFE <b>Gussie KRAUSE</b>
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>491 22 4177</b>	17. INFORMANT Address <b>Gussie KRAUSE 5409 Euclid</b>

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH <b>7-10 days</b> <b>SEVERAL YEARS</b>
IMMEDIATE CAUSE (a) <b>Pneumonia, nt.</b>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Emphysema; pulmonary</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) <b>malnutrition</b>	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
--	--

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 <b>12:30</b> a.m. <b>p.m.</b> Month, Day, Year	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 **April 1956** to **August 1960** and last saw him alive on **August 26, 1960**  
Death occurred at **12:30 P.M.** on the date stated above, and to the best of my knowledge from the causes stated.

22a. SIGNATURE (Degree or title) <b>Alexander Shifrin M.D.</b>	22b. ADDRESS <b>701 East, 63rd, K.C. 10, Mo.</b>	22c. DATE SIGNED <b>8/29/60</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>8-30-1960</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Floral Hills</b>
23d. LOCATION (City, town, or county) <b>Kansas City Mo.</b>		(State)

24. FUNERAL DIRECTOR <b>Floral Hills Memorial Chapel</b>	ADDRESS <b>K.C. Mo.</b>	25. DATE RECD. BY LOCAL REG. <b>8-29-60</b>	26. REGISTRAR'S SIGNATURE <b>H-L. Dwyer</b>
---	----------------------------	--	--

DOCUMENT

BY AFFIDAVIT OF Alexander Shifrin, M.D. Medical Certification

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Ernest D. Goldano

Licensed Embalmer No. 4717

P. O. Address KP

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