

IRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS. AUG 22 1960

=60-030644

STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4061

1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)			
a. COUNTY Jackson		b. CITY (If outside corporate limits, give TOWNSHIP only) Kansas City		a. STATE Missouri		b. COUNTY Jackson	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION Menorah Medical Center		Length of stay in lb 3 Days		c. CITY OR TOWN Kansas City		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS 517 East 61st Street		(If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)				4. DATE OF DEATH			
First Blanche		Middle Levy		Last Levy		Month Day Year 8 8 60	
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 1-13-1885	9. AGE (last birthday) 75	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) At Home		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) Jamesport, Missouri		12. CITIZEN OF WHAT COUNTRY U. S. A.	
13a. FATHER'S NAME William Gilliland			13b. MOTHER'S MAIDEN NAME Sallie Alice Clendener			14. NAME OF HUSBAND OR WIFE Charles E. Levy	
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 Mrs. Alice Bullock Kansas City, Mo.			
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
IMMEDIATE CAUSE (a) Bronchopneumonia, both lower lobes							
Pneumothorax, left atelectosis left lung							
DUE TO (b) Atherosclerotic, abdominal antic aneurysm							
DUE TO (c)							
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. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input 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 Month, Day, Year a.m. 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 COUNTY STATE	
21. I attended the deceased from <u>August 6, 1960</u> to <u>August 8, 1960</u> and last saw her ^{her} _{him} alive on <u>August 8, 1960</u> Death occurred at <u>7:30 A.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) Hugh W. Mc Caughy MD				22b. ADDRESS 5615 Johnson & Mission Km			22c. DATE SIGNED: 8-8-60
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 8-8-60	23c. NAME OF CEMETERY OR CREMATORY Adath Cemetery		23d. LOCATION (City, town, or county) (State) St. Joseph, Missouri			
24. FUNERAL DIRECTOR ADDRESS Freeman Mortuary Kansas City, Mo.			25. DATE RECD. BY LOCAL REG. 8-8-60	26. REGISTRAR'S SIGNATURE H. L. Dwyer			

DOCUMENT

BY AFFIDAVIT OF **Hugh W. Mc Caughy** MEDICAL CERTIFICATION

VS AUG 22 1960

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



Licensed Embalmer No. 293

P. O. Address J. C. Green

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.