

# FEDERAL BUREAU OF INVESTIGATION FEDERAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS AUG 3 1960

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4413 5952

-60-031616

STATE FILE NUMBER

ENDED

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. \_\_\_\_\_

<b>1. PLACE OF DEATH</b> a. COUNTY <u>PIKE</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>FRANKFORD SPENCERTWNS</u> Length of stay in 1b <u>41 YRS.</u> c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>-----</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>PIKE</u> c. CITY OR TOWN <u>SPENCER TOWNSHIP</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>5 MI. WEST OF FRANKFORD</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <u>MYRTLE WHITESIDE KURZ</u>			<b>4. DATE OF DEATH</b> Month Day Year <u>JULY 18 1960</u>		
<b>5. SEX</b> <u>FEMALE</u>	<b>6. COLOR OR RACE</b> <u>WHITE</u>	<b>7. Married</b> <input checked="" type="checkbox"/> <b>Never Married</b> <input type="checkbox"/> <b>Widowed</b> <input type="checkbox"/> <b>Divorced</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>JAN 16 1879</u>	<b>9. AGE (last birthday)</b> <u>82</u>	IF UNDER 1 YEAR Months Days Hours Min.
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (City and state or country) <u>MIDDLETOWN Mo</u>	<b>12. CITIZEN OF WHAT COUNTRY</b> <u>U.S.A.</u>
<b>13a. FATHER'S NAME</b> <u>GILCHRIST PORTER WHITESIDE</u>		<b>13b. MOTHER'S MAIDEN NAME</b> <u>MARY RODGERS</u>		<b>14. NAME OF HUSBAND OR WIFE</b> <u>ADOLPH KURZ</u>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		<b>16. SOCIAL SECURITY NO.</b> <u>492-42-5551B</u>		<b>17. INFORMANT</b> Address <u>ADOLPH KURZ FRANKFORD Mo</u>	
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypostatic Pneumonia</u> DUE TO (b) <u>Arteriosclerosis, Stroke Senility</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. 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					INTERVAL BETWEEN ONSET AND DEATH
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>	<b>20a. ACCIDENT</b> <input type="checkbox"/> <b>SUICIDE</b> <input type="checkbox"/> <b>HOMICIDE</b> <input type="checkbox"/>	<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.)			
<b>20c. TIME OF INJURY</b> Hour a.m. p.m. Month, Day, Year		<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> <b>NOT WHILE AT WORK</b> <input type="checkbox"/>			
<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>20f. CITY, TOWN, OR LOCATION</b> COUNTY STATE			
<b>21. I attended the deceased from</b> <u>1948</u> <b>to</b> <u>July 1960</u> <b>and last saw her</b> <u>live on July 17, 1960</u> <b>Death occurred at</b> <u>1:30 P.M.</u> <b>on the date stated above, and to the best of my knowledge, from the causes stated.</b>					
<b>22a. SIGNATURE</b> (Degree or title) <u>E. P. Hansen D.O.</u>			<b>22b. ADDRESS</b> <u>Frankford Mo.</u>		<b>22c. DATE SIGNED</b> <u>7-20-60</u>
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>BURIAL</u>		<b>23b. DATE</b> <u>JULY 20 1960</u>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>FAIRVIEW CEMETARY</u>		<b>23d. LOCATION</b> (City, town, or county) (State) <u>FRANKFORD MISSOURI</u>
<b>24. FUNERAL DIRECTOR</b> ADDRESS <u>MEGOWN FUNERAL HOME FRANKFORD Mo.</u>			<b>25. DATE RECD. BY LOCAL REG.</b> <u>July 26 - 60</u>		<b>26. REGISTRAR'S SIGNATURE</b> <u>Bernice Collier</u>

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**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 Isaac Fields Meyerson

Licensed Embalmer No. 4093

P. O. Address Frankford Pa

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.