

DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

EILED VS OCT 14 1960

-60-034912

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4910 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 1b 50 yrs		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 Osteopathic Hospital			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 8329 Ward Parkway		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First Oltie Middle Meng Last Meng				4. DATE OF DEATH Month Sept. Day 28, Year 1960									
5. SEX Female		6. COLOR OR RACE White		7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH Dec. 7, 1895		9. AGE (last birthday) 64		IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0		IF UNDER 24 HR Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (City and state or country) Saline, County, Mo.		12. CITIZEN OF WHAT COUNTRY U. S. A.			
13a. FATHER'S NAME Arch Goodloe				13b. MOTHER'S MAIDEN NAME Hettie Black				14. NAME OF HUSBAND OR WIFE Winfred Meng					
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. —		17. INFORMANT Winfred Meng, 8329 Ward. Pkwy, K. C., Mo Address							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Medullary Paralysis DUE TO (b) Vertebral - Basilar arterial thrombin clays DUE TO (c) cerebral arterial sclerosis Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.										INTERVAL BETWEEN ONSET AND DEATH minutes			
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 checked="" 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 5:28 a.m. 28 p.m.		Month, Day, Year 9/26/60											
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 9/26/60 to 9/28/60 and last saw ^{her} alive on 9/28/60 Death occurred at 5:28 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE (Degree or title) Milton S. Steinberg M.D.						22b. ADDRESS 926 E. 11th St., K.C. 6, Mo			22c. DATE SIGNED 9/28/60				
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 9-30-60		23c. NAME OF CEMETERY OR CREMATORY Ridge Park			23d. LOCATION (City, town, or county) Marshall, Missouri			(State)			
24. FUNERAL DIRECTOR Stine & McClure, Kansas City, Mo.				25. DATE RECD. BY LOCAL REG. 9-29-60		26. REGISTRAR'S SIGNATURE H-L. Dwyer							

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

Milton S. Steinberg

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 William M. J...

Licensed Embalmer No. 464
P. O. Address Kansas City

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.