

IRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-035008

FILED VS. OCT 14 1960

149

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

4897

STATE FILE NUMBER

INDEXED

DOCUMENT

BY AFFIDAVIT OF
Milton S. Steinberg
MEDICAL CERTIFICATION

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) OR TOWN Kansas City		a. STATE Missouri b. COUNTY Jackson		c. CITY OR TOWN Kansas City	
Length of stay in 1b 41 yrs.		Inside Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		Inside Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		Reside on Farm <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Osteopathic Hospital				d. STREET ADDRESS (If outside, give location) 5534 Crestwood Drive			
3. NAME OF DECEASED (Type or print)			4. DATE OF DEATH			Month Day Year	
First Mary Middle Mae Last Saunders			September 27, 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 7-26-1867	9. AGE (last birthday) 93	IF UNDER 1 YEAR	IF UNDER 24 HR	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (City and state or country) Prague, Bohemia		12. CITIZEN OF WHAT COUNTRY USA		
13a. FATHER'S NAME James Halepeska			13b. MOTHER'S MAIDEN NAME Anna (Unknown)			14. NAME OF HUSBAND OR WIFE Lyman H. Saunders	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/> No		16. SOCIAL SECURITY NO. —		17. INFORMANT Address Mrs. John D. Howard, 5534 Crestwood Dr. K.C. 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) Medullary Paralysis						Hours	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last: DUE TO (b) Cerebral Anoxiema						Days	
DUE TO (c) Bronchial Pneumonia						Days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Arterial occlusion of left femoral artery and Nasal fracture					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 checked="" 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.) Dizzy spell three weeks ago with fall at home					
20c. TIME OF INJURY Hour <input checked="" type="checkbox"/> a.m. <input type="checkbox"/> p.m. 8-31-60							
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.) Home		20f. CITY, TOWN, OR LOCATION Kansas City		COUNTY STATE Jackson Missouri	
21. I attended the deceased from 9-21-60 to 9-27-60 and last saw her alive on 9-27-60 . Death occurred at 2:45 a.m. on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Of declarant or title) Milton S. Steinberg M.D.				22b. ADDRESS 926 E. 11th, Kansas City, Mo.			22c. DATE SIGNED 9-27-60
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 9-29-60	23c. NAME OF CEMETERY OR CREMATORY City Cemetery		23d. LOCATION (City, town, or county) (State) Tecumseh, Nebraska		
24. FUNERAL DIRECTOR Melody-McGilley-Eylar, ADDRESS 20 West Linwood K. C. Mo.		25. DATE RECD. BY LOCAL REG. 9-28-60		26. REGISTRAR'S SIGNATURE H-L. Dwyer			

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 Wm. H. Lentz

Licensed Embalmer No. 5038

P. O. Address K.C. Mo.

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.