

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-038453

FILED VS OCT 27 1960

149

Primary Registration District No. 1002

Registrar's No. 5091

STATE FILE NUMBER

INDEXED

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 6 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 2725 Campbell		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 2725 Campbell		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First SARAH Middle Last LOMBARDI			4. DATE OF DEATH Month October Day 9 Year 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 10/3/1896	9. AGE (last birthday) 64 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) housework		10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (City and state or country) Mt Vernon, N.Y.	12. CITIZEN OF WHAT COUNTRY USA	
13a. FATHER'S NAME Michael O'Shea		13b. MOTHER'S MAIDEN NAME Lois Vandewater		14. NAME OF HUSBAND OR WIFE —		
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. no	17. INFORMANT Address Mrs Lois Copowycz 7001 Ky. Raytown, Mo			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction, Acute, Severe					INTERVAL BETWEEN ONSET AND DEATH 1 Hr.	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Arteriosclerosis, Atherosclerosis, coronary artery system, severe, Chronic					10 Yrs	
DUE TO (c) Arteriosclerosis, Generalized, severe					10 Yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal condition given in PART I (a) Hypertension, arterial, severe, Obesity, marked, exogenous.				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.) None		
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m. None		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> None				
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) None		20f. CITY, TOWN, OR LOCATION None		COUNTY STATE		
21. I attended the deceased from July 1951 , to 10/9/60 and last saw her her alive on 10-8-60 Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.						
22a. SIGNATURE Harsed A. Budke MD			22b. ADDRESS Argyle Bldg. K.C.MO.		22c. DATE SIGNED 10/10/60	
23a. BURIAL, CREMATION REMOVAL (Specify) removal	23b. DATE 10/10/60	23c. NAME OF CEMETERY OR CREMATORY Holy Sepulchrs Cemetery		23d. LOCATION (City, town, or county) (State) New Rochelle, N.Y.		
24. FUNERAL DIRECTOR JOS. A. BUTLER'S SONS K.C.K		ADDRESS K.C.K		25. DATE RECD. BY LOCAL REG. 10-10-60	26. REGISTRAR'S SIGNATURE H-L. Dwyer	

DOCUMENT

MEDICAL CERTIFICATION

Budke

BY AFFIDAVIT OF

2807

111

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 _____
Doss Bee

Licensed Embalmer No. 3426

P. O. Address Kansas City

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.