

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-042226

FILED VS. DEC 12 1960

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Primary Registration District No. 1002

Registrar's No. 5813

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Kansas</b> b. COUNTY <b>Wyandotte</b>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kansas City</b>		Length of stay in 1b <b>6 days</b>	c. CITY OR TOWN <b>Kansas City</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. Joseph Hospital</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>Monastery of St. Augustine 33rd and Parallel</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>MARK (JOHN) FRANCIS REBAR</b>			4. DATE OF DEATH Month Day Year <b>November 15, 1960</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>11-25-1925</b>	9. AGE (last birthday) <b>34</b> IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Religious Brother</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Catholic Monastery</b>	11. BIRTHPLACE (City and state or country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13a. FATHER'S NAME <b>Francis Rebar</b>		13b. MOTHER'S MAIDEN NAME <b>Caroline Habada</b>		14. NAME OF HUSBAND OR WIFE <b>- - -</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT Address <b>Monastery of Rev. Leonary Raca, ORSA, St. Augustine</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cong. Tric Heart Failure</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. ) DUE TO (b) <b>Congenital Heart Disease - Tetralogy</b> DUE TO (c) <b>Post operative failure</b>					INTERVAL BETWEEN ONSET AND DEATH <b>24 hours</b>	
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 checked="" 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 a.m. p.m. Month, Day, Year	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 <b>July 1946</b> to <b>Nov. 15, 1960</b> and last saw <b>him</b> alive on <b>11/15/60</b> Death occurred at <b>11 05</b> <b>P</b> m on the date stated above, and to the best of my knowledge, from the causes stated.						
22a. SIGNATURE <b>Nector W. Benoit</b> (Name or title)			22b. ADDRESS <b>#620 Tichel Pkwy K.C. Mo.</b>		22c. DATE SIGNED <b>11/18/60</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>11-16-1960</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Calvary</b>		23d. LOCATION (City, town, or county) (State) <b>Kansas City, Kansas</b>		
24. FUNERAL DIRECTOR <b>Matt Skradski</b> ADDRESS <b>Skradski - Stine F. H. K.C.K.</b>			25. DATE RECD. BY LOCAL REG. <b>11-18-60</b>	26. REGISTRAR'S SIGNATURE <b>H. L. Dwyer</b>		

DOCUMENT

BY AFFIDAVIT OF Nector W. Benoit, J. MEDICAL CERTIFICATION

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*Handwritten notes:*  
 1. Embalmer's name  
 2. Date of embalming  
 3. Location of embalming

**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 \_\_\_\_\_

Signed Matt Stradski

Signature of Student Embalmer

Licensed Embalmer No. 4382

P. O. Address R. O. R.

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.