

SOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-017401

STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 2507

AMENDED

FILED JUN 5 1961

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kansas City</u>		Length of stay in 1b <u>67 Yrs.</u>	c. CITY OR TOWN <u>Kansas City</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Baptist Hosp.</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>15 East Meyer</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Sally</u> Middle <u>Donovitz</u> Last <u>Donovitz</u>			4. DATE OF DEATH Month <u>May</u> Day <u>19</u> Year <u>1961</u>		
---	--	--	---	--	--

5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>12/10/93</u>	9. AGE (last birthday) <u>67</u>	IF UNDER 1 YEAR Months <u>4</u> Days <u>8</u> Hours <u>15</u> Min.		IF UNDER 24 HR Hours <u>15</u> Min.
----------------------	-------------------------------	--	----------------------------------	----------------------------------	---	--	--

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	11. BIRTHPLACE (City and state or country) <u>Kansas City, Mo.</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
--	---	--	---

13a. FATHER'S NAME <u>Max Marshock</u>	13b. MOTHER'S MAIDEN NAME <u>Bessie</u>	14. NAME OF HUSBAND OR WIFE <u>Louis Donovitz</u>
--	---	---

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	16. SOCIAL SECURITY NO. <u>-----</u>	17. INFORMANT <u>Benne Yukon, 15 East Meyer K.C., Mo.</u> 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) <u>Terminal Pneumonia</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 8 hours</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Brain metastases</u>		<u>1 1/2 months</u>
	DUE TO (c) <u>Ca. of the breast</u>		<u>about 1/2 year</u>
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 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 <u>5:30</u> a.m. <u>p.m.</u> Month, Day, Year	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.)	20f. CITY, TOWN, OR LOCATION	COUNTY	STATE
---	---	--	------------------------------	--------	-------

21. I attended the deceased from <u>Nov 4 1960</u> to <u>May 19 1961</u> last saw her/him live on <u>May 19 1961</u> Death occurred at <u>5:30 P.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.	
---	--

22a. SIGNATURE (Degree or title) <u>L. M. Shapiro</u>	22b. ADDRESS <u>701 E 63rd St #201</u>	22c. DATE SIGNED <u>5-22-61</u>
---	--	---------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>5/22/1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>MtCarmel Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Kansas City, Missouri</u>
---	----------------------------	---	--

24. FUNERAL DIRECTOR <u>J.P. Louis Funeral Home, K.C., Mo.</u> ADDRESS	25. DATE RECD. BY LOCAL REG. <u>5-22-61</u>	26. REGISTRAR'S SIGNATURE <u>Ruth Long</u>
---	---	--

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed *Henry Buffington*

Licensed Embalmer No. 2756

P. O. Address RC 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.