SSOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

RTMENT OF PUBLIC HEALTH AND WELFARE

-61-021290 ✓
STATE FILE NUMBER

AMENDED

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 2914

FILED JUN 28 1961

1. PLACE OF DEATH
a. COUNTY Jackson
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City
Length of stay in 1b: Life
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Luke's Hosp
Inside Limits: Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY Jackson
c. CITY OR TOWN Kansas City
Inside Limits: Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location) 434 W. 57th St. Ter
Reside on Farm: Yes ☐ No ☒

3. NAME OF DECEASED (Type or print): First GEORGE Middle PETER Last HELLER
4. DATE OF DEATH: Month June Day 11 Year 1961
5. SEX: Male
6. COLOR OR RACE: White
7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐
8. DATE OF BIRTH: 12-1-1900
9. AGE (last birthday): 60
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): Retired Owner
10b. KIND OF BUSINESS OR INDUSTRY: Machinery Dit-Mco, Inc
11. BIRTHPLACE (City and state or country): Kansas City, Mo
12. CITIZEN OF WHAT COUNTRY: U.S.A.
13a. FATHER'S NAME: George Heller
13b. MOTHER'S MAIDEN NAME: Emma Stanhart
14. NAME OF HUSBAND OR WIFE: Florence O. Heller
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): --
17. INFORMANT: Mrs. Florence Heller Address: 434 W. 57 T Kan.City 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) Carcinomatosis — INTERVAL BETWEEN ONSET AND DEATH: 4 months
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Carcinoma of the recto-sigmoid — 4 months
DUE TO (c)
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. ☐ Yes ☐ No ☐ Unknown

MEDICAL CERTIFICATION — Edward H. Klein

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
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 ☐ NOT WHILE AT WORK ☐
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 3/2/61 to 6/11/61 and last saw her/him alive on 6/11/61
Death occurred at 12:00 NOON m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Edward H Klein M.D. (Degree or title)
22b. ADDRESS Plaza Med. Bldg KC-12-Mo
22c. DATE SIGNED 6/12/61

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: June 14, 61
23c. NAME OF CEMETERY OR CREMATORY: Forest Hill Cem
23d. LOCATION (City, town, or county) (State): Kansas City Missouri

24. FUNERAL DIRECTOR: D.W. Newcomer's Sons ADDRESS 531 Br.Ck Kan.City, Mo
25. DATE RECD. BY LOCAL REG.: 6-13-61
26. REGISTRAR'S SIGNATURE: Ruth W. Long

(Licensed Embalmer's Statement on Reverse Side)

DATE AMENDED | INSTEAD OF | SHOULD READ | ITEM NO. | DOCUMENT | BY AFFIDAVIT OF

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_____ Signed _____

Signature of Student Embalmer

Licensed Embalmer No. 3035

P. O. Address _____

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.