

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

=61-036276
STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4933

AMENDED
FILED OCT 19 1961

DATE AMENDED

INSTEAD OF THIS RECORD ARE AS FOLLOWS

ITEM NO. SHOULD READ

DOCUMENT

BY AFFIDAVIT OF
Phillip H. Halperin
MEDICAL CERTIFICATION

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) Kansas City		c. CITY OR TOWN Kansas City	
Length of stay in 1b 2 Mo		Inside Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION Menorah Medical Center		d. STREET ADDRESS (If outside, give location) 229 Ward Parkway	
Inside Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		Reside on Farm <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
3. NAME OF DECEASED (Type or print) First O. Paul Middle B. Last Beretz			4. DATE OF DEATH Month October Day 4 Year 1961
5. SEX Male	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 5-12-05
9. AGE (last birthday) 56		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Financial Analyst		10b. KIND OF BUSINESS OR INDUSTRY Pipe Line Co.	11. BIRTHPLACE (City and state or country) HUNGARY
12. CITIZEN OF WHAT COUNTRY		13a. FATHER'S NAME Basil Beretz	
13b. MOTHER'S MAIDEN NAME Anna Medvecky		14. NAME OF HUSBAND OR WIFE MARTHE E. BERETZ	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No or unknown) (If yes, give year or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. MARTHE E. BERETZ Home		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) Embolism L. Pulmonary artery DUE TO (b) Thrombus L. pulmonary artery DUE TO (c) Cancer Rt. Lung. Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH
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 Month, Day, Year a.m. p.m.		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 9-13-61 to 10-4-61 and last saw her/him alive on 10-4-61		Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE (Sign as doctor or title) Phillip H. Halperin M.D.		22b. ADDRESS 751 E. 63rd.	
22c. DATE SIGNED 10-5-61		23a. BURIAL (CREMATION, REMOVAL) (Specify) Removal	
23b. DATE 10-5-61		23c. NAME OF CEMETERY OR CREMATORY St. Mary's	
23d. LOCATION (City, town, or county) (State) Yonkers, N. Y.		24. FUNERAL DIRECTOR Melody McGilley-Eyles	
ADDRESS 20 W. Lincoln		25. DATE RECD. BY LOCAL REG. 10-5-61	
26. REGISTRAR'S SIGNATURE Ruth Long			

De 3 - 2000

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 Wm. H. Gentry

Licensed Embalmer No. 5038

P. O. Address KC 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.