

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

62-006589
STATE FILE NUMBER

AMENDED

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 743

FILED FEB 28 1962

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| 1. PLACE OF DEATH | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) | |
| a. COUNTY Jackson | b. CITY (If outside corporate limits, give TOWNSHIP only) Kansas City | a. STATE Missouri | b. COUNTY Jackson |
| Length of stay in 1b 27 years | | 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 Menorah Medical Center | | d. STREET ADDRESS 4521 Tracy Avenue | (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |

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|-------------------------------------|------------------------|---------------------|-----------------------|------------------|--------------------------|------------------|---------------------|
| 3. NAME OF DECEASED (Type or print) | First Marion | Middle R. | Last Levene | 4. DATE OF DEATH | Month February | Day 6, | Year 1962 |
|-------------------------------------|------------------------|---------------------|-----------------------|------------------|--------------------------|------------------|---------------------|

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|-------------------------|----------------------------------|---|------------------------------------|--|---|----------------|
| 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 5-13-92 | 9. AGE (last birthday) 70-69 | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HR |
|-------------------------|----------------------------------|---|------------------------------------|--|---|----------------|

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| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker-At Home | 10b. KIND OF BUSINESS OR INDUSTRY Domestic | 11. BIRTHPLACE (City and state or country) New York, New York | 12. CITIZEN OF WHAT COUNTRY U. S. A. |
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| 13a. FATHER'S NAME William Loftus | 13b. MOTHER'S MAIDEN NAME Unknown | 14. NAME OF HUSBAND OR WIFE Josiah S. Levene |
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| 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. None | 17. INFORMANT Marie Levene, 4521 Tracy Avenue, Kansas City, Missouri |
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| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: | INTERVAL BETWEEN ONSET AND DEATH |
| IMMEDIATE CAUSE (a) Generalized Carcinomatosis | 8 months |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Carcinoma of stomach | |
| DUE TO (c) | |

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| 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 checked="" type="checkbox"/> No <input type="checkbox"/> Unknown |
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| 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.) |
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| 20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year |
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|--|--|---|---------------------------|-------|
| 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 1946 | COUNTY Missouri | STATE |
|--|--|---|---------------------------|-------|

21. I attended the deceased from **1946** to _____ and last saw her ^{him} alive on **2-5-62**
Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.

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| 22a. SIGNATURE (Deceased or title) Harry K. Cohen M.D. | 22b. ADDRESS 751 E-63rd St. | 22c. DATE SIGNED 2-6-62 |
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| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE Feb. 8, 1962 | 23c. NAME OF CEMETERY OR CREMATORY Mount Moriah Cemetery | 23d. LOCATION (City, town, or county) (State) Kansas City Missouri |
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| 24. FUNERAL DIRECTOR D.W. Newcomer's Sons, Kansas City, Mo. | ADDRESS 1331 Brush Creek Blvd. | 25. DATE RECD. BY LOCAL REG. 2-8-62 | 26. REGISTRAR'S SIGNATURE Ruth Long |
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(Licensed Embalmer's Statement on Reverse Side)

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
 DATE AMENDED
 INSTEAD OF
 DOCUMENT
 BY AFFIDAVIT OF
 MEDICAL CERTIFICATION
 Harry K. Cohen

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 Robert Ray

Licensed Embalmer No. 4182

P. O. Address K. C., 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.