

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

= 62-015114
2032 STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

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

FILED APR 30 1962

VS 300	DATE AMENDED	AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
Rev. 4/59		
1		
2 <u>3588</u>		
3		
4 <u>1</u>		
5 <u>2</u>		
6		
7 <u>2</u>		
8 <u>0</u>		
9 <u>420-0</u>		
10		
11		
12 <u>64-0</u>		
13		
	INSTEAD OF	DOCUMENT
	SHOULD READ	BY AFFIDAVIT OF
	ITEM NO.	MEDICAL CERTIFICATION

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>51 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>Research Hospital</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>3111 Spruce</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Katherine</u> Middle _____ Last <u>Blumel</u>		4. DATE OF DEATH Month <u>April</u> Day <u>10</u> Year <u>1962</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>11-25-1885</u>
9. AGE (last birthday) <u>76</u>		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) <u>AT HOME</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>Budapest Hungary</u>
12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		13. FATHER'S NAME <u>UNKNOWN Polangi</u>	
14. MOTHER'S MAIDEN NAME <u>ANNA Velos</u>		14. NAME OF HUSBAND OR WIFE <u>John Blumel</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>None</u>	
17. INFORMANT <u>Mr. John T. Blumel</u>		Address <u>6920 Russell Overland</u>	
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>Acute Myocardial Infarction</u> DUE TO (b) <u>Coronary occlusion and previous infarction</u> DUE TO (c) <u>Arteriosclerotic Cardiac Disease.</u> 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) <u>Generalized Arteriosclerosis</u>			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 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 <u>6 April 1956</u> to <u>10 April '62</u> and last saw her alive on <u>10 April 1962</u> . Death occurred at <u>10 April '62 - 11:39 A.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Wallace H. Graham M.D.</u>		22b. ADDRESS <u>518 Argyle Bldg. K.C., Mo.</u>	22c. DATE SIGNED <u>11 April '62</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>4-12-62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>MT. Moriah</u>	23d. LOCATION (City, town, or county) <u>K.C. Mo.</u>
24. FUNERAL DIRECTOR <u>Stire & McClure</u>	ADDRESS <u>K.C. Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>4-12-62</u>	26. REGISTRAR'S SIGNATURE <u>Ruth Long</u>

*Dr Wallace Lindan
Dr Wilson Miller
No 1-6111
518 Campbell Bldg
Lisp Sp m case.*

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 William M. Turner

Licensed Embalmer No. 4648

P. O. Address Kansas City, 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.