

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-015499

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 149

Primary Registration District No. 1002 Registrar's No. 2024

2024

FILED APR 30 1962

VS 300
Rev. 4/59

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2 3588
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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF
Philip G. Kaul

USE BLACK INK OR TYPEWRITER RIBBON

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) <u>Kansas City</u>			Length of stay in 1b <u>55 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>4922 E. 41st. St.</u>				Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>4922 E. 41st. St.</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <u>STELLA</u> Middle <u>ANN</u> Last <u>TAAFFE</u>						4. DATE OF DEATH Month <u>April</u> Day <u>9</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>10-27-1883</u>		9. AGE (last birthday) <u>78</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>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (City and state or country) <u>Burlington, Iowa</u>		12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>					
13a. FATHER'S NAME <u>Henry Grass</u>				13b. MOTHER'S MAIDEN NAME <u>Brigett Kelly</u>				14. NAME OF HUSBAND OR WIFE <u>Frank J. Taaffe</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 Address <u>Mr. Frank Taaffe, Jr. 4922 E. 41st. St.</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>Hepatic Coma & inanition</u>										INTERVAL BETWEEN ONSET AND DEATH <u>2-3 days.</u>			
Conditions, if any, which gave rise to above cause (a), stating the underlying cause: last. DUE TO (b) <u>Extensive abdominal & Hepatic metastatic Adenocarcinoma</u>										<u>3 mos.</u>			
DUE TO (c) <u>Adenocarcinoma of Gall Bladder.</u>										<u>9 mos.</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 checked="" 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>17 Jan. 1962</u> to <u>9 April 1962</u> and last saw ^(or) him alive on <u>17 Jan. 1962</u> . Death occurred at <u>7:30 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>Philip G. Kaul M.D.</u>						22b. ADDRESS <u>7320 Wornall Rd. K.C. 4, Mo.</u>			22c. DATE SIGNED <u>4-11-1962</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE <u>4-12-62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Mary's Cemetery</u>			23d. LOCATION (City, town, or county) (State) <u>Kansas City, Missouri</u>					
24. FUNERAL DIRECTOR <u>Melody-McGilley-Eylar</u>				ADDRESS <u>Woodland</u>		25. DATE RECD. BY LOCAL REG. <u>4-11-62</u>		26. REGISTRAR'S SIGNATURE <u>Ruth Long</u>					

Mr. Haul
Plaza Time Bldg.

Je. 1 - 2328
Wed: 1:00 to 5:00

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

Gerald A. Burger

Licensed Embalmer No. 4763

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.