

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

5842 -62-042726
STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 5842

FILED DEC 10 1962

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Rev. 4/59

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DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY JACKSON		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE KANSAS b. COUNTY JOHNSON	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN KANSAS CITY, MISSOURI		Length of stay in 1b 22 days	c. CITY OR TOWN SHAWNEE, KS. Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION VA HOSPITAL, KC, MO.		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 4725 Belender Ct. Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First SAMUEL Middle NONE Last KAPLAN			4. DATE OF DEATH Month NOV. Day 17, Year 1962
5. SEX MALE	6. COLOR OR RACE CAUCASIAN	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 3/1/94
9. AGE (last birthday) 68		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CLOTHING CUTTER		10b. KIND OF BUSINESS OR INDUSTRY CLOTHING	11. BIRTHPLACE (City and state or country) VILNA, RUSSIA
12. CITIZEN OF WHAT COUNTRY U.S.A		13a. FATHER'S NAME JACOB KAPLAN	
13b. MOTHER'S MAIDEN NAME BESSIE PODBERESKY		14. NAME OF HUSBAND OR WIFE VERDA KAPLAN	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) If yes, give year or dates of service YES 17/30/18 to 12/15/18		17. INFORMANT Address Mrs Verda Kaplan, 4725 Belender, Shawnee, KANSAS	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia and passive congestions of lungs DUE TO (b) Carcinoma of lung, advanced with widespread metastasis DUE TO (c) _____ 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 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
21a. attended the deceased from 10/27/62 to Nov 17, 1962 and last saw ^{her} him alive on 11/17/62		Death occurred at 10:30 PM 11/17/62 m on the date stated above, and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE James M. Flynn M.D.		22b. ADDRESS VA Hospital, K.C., Mo.	22c. DATE SIGNED 11-18-62
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 11-20-62	23c. NAME OF CEMETERY OR CREMATORY Floral Hills	23d. LOCATION (City, town, or county) (State) Kansas City, Missouri
24. FUNERAL DIRECTOR ADDRESS Floral Hills Funeral Home Kansas City, Mo.		25. DATE RECD. BY LOCAL REG. 11-20-62	26. REGISTRAR'S SIGNATURE Ruth Long

USE BLACK INK OR TYPEWRITER RIBBON

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 E. M. Jones

Licensed Embalmer No. 3453

P. O. Address H. E. Lane

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.