

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

608363-044058

DO NOT WRITE ON THIS STUB

AMENDED

VS 300
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF JACK W. WOLF

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 608363-044058

FILED DEC - 2 1963

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</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 Tb <u>56yrs</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>Menorah Med. Center</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>4618 Warwick</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>Cecil</u> Middle <u>M</u> Last <u>Kohn</u>			4. DATE OF DEATH Month <u>Nov.</u> Day <u>7</u> Year <u>1963</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Wh</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>6/28/07</u>	9. AGE (last birthday) <u>56</u>	IF UNDER 1 YEAR Months <u></u> Days <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Physician</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Medical</u>	11. BIRTHPLACE (City and state or country) <u>Kansas City, Mo.</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>Abe Kohn</u>		13b. MOTHER'S MAIDEN NAME <u>Edith Terte</u>		14. NAME OF HUSBAND OR WIFE <u>Carolyn Kohn</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>Unknown</u>	17. INFORMANT Address <u>Carolyn Kohn 4618 Warwick</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>	INTERVAL BETWEEN ONSET AND DEATH <u>2 months</u>
DUE TO (b) <u>Arteriosclerotic Heart Disease</u>	<u>2 months</u>
DUE TO (c) _____	

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)
Diabetes Mell. Ins

PART III. If deceased was female was there a pregnancy in last 90 days.
 Yes No 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 _____ 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 1950 to Nov 7, 1963 and last saw him alive on Nov. 7, 1963
Death occurred at 8 45 A on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>Jack W. Wolf M.D.</u>	22b. ADDRESS <u>408 E. 63 St Kansas City Mo.</u>	22c. DATE SIGNED <u>11/8/63</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>11/8/63</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill</u>
23d. LOCATION (City, town, or county) <u>Kansas City, Mo.</u>		(State)

24. FUNERAL DIRECTOR <u>Louis Memorial Chapel, K.C., Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>11-8-63</u>	26. REGISTRAR'S SIGNATURE <u>Bessie Smith</u>
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USE BLACK INK OR TYPEWRITER RIBBON

[Faint, mostly illegible text from the reverse side of the certificate is visible through the paper.]

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603
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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 *Key Ruffington*

Licensed Embalmer No. 2756

P. O. Address H.C. 710

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.