

FILED NOV 18 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 37299

BIRTH NO. 73219-49 REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. 4541

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE Missouri b. COUNTY JACKSON	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kansas City		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kansas City	
d. FULL NAME OF HOSPITAL OR INSTITUTION Menorah Hospital		d. STREET ADDRESS (If rural, give location) 1221 West 38th	

3. NAME OF DECEASED a. (First) ROBERT a. (Middle) MICHAEL c. (Last) Wall			4. DATE OF DEATH (Month) (Day) (Year) 10-2-50		
5. SEX M	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single	8. DATE OF BIRTH Nov 14 1949	9. AGE (In years last birthday) 11 18	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY none	11. BIRTHPLACE (State or foreign country) Kansas City, Missouri		12. CITIZEN OF WHAT COUNTRY? U. S.

13a. FATHER'S NAME J Leonard Wall	13b. MOTHER'S MAIDEN NAME Maude Brosnahan	14. NAME OF HUSBAND OR WIFE
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no	16. SOCIAL SECURITY NO. none	17. INFORMANT'S SIGNATURE OR NAME J Leonard Wall	ADDRESS 1221 West 38th
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute Diphtheria - Trachea Bronchitis		INTERVAL BETWEEN ONSET AND DEATH 36 hrs
		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Follicular Pharyngitis		
		DUE TO (c)		
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		57A

19a. DATE OF OPERATION 10-31-50	19b. MAJOR FINDINGS OF OPERATION Bronchoscopy - E Removal of Membrane 10/31/50 Tracheotomy 11-1-50	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10-31, 1950, to 11-2, 1950, that I last saw the deceased alive on 11-2, 1950, and that death occurred at 1:45A. m., from the causes and on the date stated above.

23a. SIGNATURE Sidney T Pakula (Degree or title) Sidney T Pakula MD	23b. ADDRESS 411 Nichols Rd, KC Mo	23c. DATE SIGNED 11/2/50
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 11/3/50	24c. NAME OF CEMETERY OR CREMATORY Mt Olivet Cemetery	24d. LOCATION (City, town, or county) (State) Kansas City Mo
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DATE REC'D BY LOCAL REG. 11-3-50	REGISTRAR'S SIGNATURE Geraldine Holmes	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Duire & 9 Olive 2011 Lenwood
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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 _____

working under my personal supervision.

Student Embalmer No.

Signed

Forrest A. Goldsnow

Signed.....
Student Embalmer

Licensed Embalmer No. *4714*

P. O. Address *Box 720*

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 this body is not embalmed, fact should be so stated above.