

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

22919
State File No. 22919
Registrar's No. 3039

FILED AUG 4 1951

BIRTH NO. 51997-57 REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MO. b. COUNTY Jackson	
b. CITY (If outside corporate limits, write RURAL and give township) Kansas City		c. CITY (If outside corporate limits, write RURAL and give township) Kansas City	
c. LENGTH OF STAY (in this place) 5 months		d. STREET ADDRESS (If rural, give location) 4724 Virginia	
d. FULL NAME OF HOSPITAL OR INSTITUTION Lakeside			

3. NAME OF DECEASED (Type or Print) a. (First) Charles b. (Middle) Reed c. (Last) Altman			4. DATE OF DEATH (Month) (Day) (Year) 7 - 17 1951		
5. SEX M.	6. COLOR OR RACE W.	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Child	8. DATE OF BIRTH 7-17-51	9. AGE (In years last birthday) 5	10. MONTHS 8
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MO	
12. CITIZEN OF WHAT COUNTRY? U.S.					

13a. FATHER'S NAME Frank C. Altman	13b. MOTHER'S MAIDEN NAME Betty Bette Bowen	14. NAME OF HUSBAND OR WIFE
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME mother Mrs Bette Altman	ADDRESS 4724 Virginia
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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, ashenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 7544
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cardio-Respiratory failure		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Ad normal Congenital DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from 7-17, 1951 to 7-17, 1951, that I last saw the deceased alive on 7-17, 1951, and that death occurred at 10:27A.M., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title)	23b. ADDRESS 5811 Truman Rd	23c. DATE SIGNED
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 7/19/51	24c. NAME OF CEMETERY OR CREMATORY Forest Hill	24d. LOCATION (City, town, or county) (State) K.C. Mo.
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DATE REC'D BY LOCAL REG. 7-18-51	REGISTRAR'S SIGNATURE Geraldine Holmes	25. FUNERAL DIRECTOR'S SIGNATURE Bates Funeral Home	ADDRESS K.C. Mo.
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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.....

Jimmy S. Hucks
.....

Licensed Embalmer No. *4092*

Signed.....
Student Embalmer

P. O. Address *Missouri, Kan*

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.