

FILED AUG 4 1951

STANDARD CERTIFICATE OF DEATH

State File No. 23290

BIRTH NO. _____ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. 3032

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) Kansas City		c. CITY (If outside corporate limits, write RURAL and give township) Kansas City	
c. LENGTH OF STAY (in this place) 50 YRS		d. STREET ADDRESS (If rural, give location) 2618 Lister	
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) General Hospital No. 1			

3. NAME OF DECEASED (Type or Print) Louise	a. (First)	b. (Middle)	c. (Last) Winter	4. DATE OF DEATH (Month) (Day) (Year) 7 14 51
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5. SEX Fe	6. COLOR OR RACE W.	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single	8. DATE OF BIRTH 3-14-1896	9. AGE (In years last birthday) (If under 1 year: Months) (If under 12 mos.: Days) (Hours) (Min.) 55
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TELEPHONE OP.	10b. KIND OF BUSINESS OR INDUSTRY RETIRED	11. BIRTHPLACE (State or foreign country) KANSAS CITY, MO	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME CHARLES ZILSKE	13b. MOTHER'S MAIDEN NAME MARY WINTER	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) NO	16. SOCIAL SECURITY NO. links	17. INFORMANT'S SIGNATURE OR NAME LOUISE MAYS	ADDRESS 2841 BATES K.C. MO
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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, asphyxia, etc. It means the disease, injury, or complication which caused death.	1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute coronary occlusion left descending		INTERVAL BETWEEN ONSET AND DEATH
	ANTECEDENT CAUSES DUE TO (b) Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		
	11. OTHER SIGNIFICANT CONDITIONS Primary carcinoma right adrenal with massive liver metastases and involvement right kidney		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	

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 **6-20**, 19**51**, to **7-14-51**, 19**51**, that I last saw the deceased alive on **7-14-51**, 19**51**, and that death occurred at **12:50 P.M.**, from the causes and on the date stated above.

23a. SIGNATURE R. J. Burns, M.D.	23b. ADDRESS 24th & Cherry	23c. DATE SIGNED 7-16-51
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24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	24b. DATE 7-17-51	24c. NAME OF CEMETERY OR CREMATORY ST. MARY'S	24d. LOCATION (City, town, or county) (State) K.C. MO
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DATE REC'D BY LOCAL REG. 7-17-51	REGISTRAR'S SIGNATURE Geraldine Holmes	25. FUNERAL DIRECTOR'S SIGNATURE Melody M^e Gilley - Fylar	ADDRESS K.C. MO
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(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

Dr. Robert

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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
Student Embalmer

Signed.....

[Handwritten Signature]
.....
Licensed Embalmer No. *[Handwritten Number]*

P. O. Address: *[Handwritten Address]*

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.