

FILED AUG 27 1953

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

28486

State File No.

3945

BIRTH NO. _____ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. 3945

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 OR TOWN Kansas City c. LENGTH OF STAY (in this place) unknown

c. CITY OR TOWN Kansas City d. Is Residence within limits of a city or incorporated town? Yes No

d. FULL NAME OF HOSPITAL OR INSTITUTION General Hospital No. 1

e. STREET ADDRESS (If rural, give location) 607 1/2 Main St. 3128

3. NAME OF DECEASED
a. (First) Fred b. (Middle) _____ c. (Last) Arten

4. DATE OF DEATH (Month) (Day) (Year)
7 30 1953

5. SEX Male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married

8. DATE OF BIRTH 11-29-1896

9. AGE (In years last birthday) 56

f UNDER 1 YEAR Months _____ Days _____ g UNDER 1 HRS. Hours _____ Min. _____

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown

10b. KIND OF BUSINESS OR INDUSTRY Unknown

11. BIRTHPLACE (City and State or Foreign Country) Russia 6

12. CITIZEN OF WHAT COUNTRY? _____

13a. FATHER'S NAME Steve Arten

13b. MOTHER'S MAIDEN NAME Unknown

14. NAME OF HUSBAND OR WIFE Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Unknown

16. SOCIAL SECURITY NO. Unknown

17. INFORMANT'S SIGNATURE OR NAME ADDRESS Hospital Records K.C.Mo.

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)
MEDICAL CERTIFICATION
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Heat stroke
INTERVAL BETWEEN ONSET AND DEATH
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.
ANTECEDENT CAUSES DUE TO (b) (r.m.o.)
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (c) _____
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.
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19a. DATE OF OPERATION _____ 19b. MAJOR FINDINGS OF OPERATION _____ 20. AUTOPSY? YES NO

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) 123 (STATE) _____

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____ 21e. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK

21f. HOW DID INJURY OCCUR? _____

22. I hereby certify that I attended the deceased from July 29, 1953, to July 30, 1953, that I last saw the deceased alive on July 30, 1953, and that death occurred at 2:45P m., from the causes and on the date stated above.

23a. SIGNATURE B. I. Burns (Degree or title) M.D.

23b. ADDRESS 24th & Cherry

23c. DATE SIGNED 7-31-53

24a. BURIAL CREMATION REMOVAL (Specify) burial

24b. DATE 8-4-1953

24c. NAME OF CEMETERY OR CREMATORY K. C. Col. of Osteo.

24d. LOCATION (City, town, or county) (State) Kansas City, Missouri

DATE REC'D BY LOCAL REG. 8-8-53 REGISTRAR'S SIGNATURE Heralding Smith

25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Robert E. Weckert K.C.Mo.

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

Was picked up and thought to be drunk.
Later the Doctors believed he had had a
heat stroke.

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 *B. E. Weir*.....

Licensed Embalmer No. *407*.....

P. O. Address *K.C. 8*.....

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.