

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

33636

State File No. \_\_\_\_\_

FILED NOV 10 1955

BIRTH NO. _____		REG. DIST. NO. <u>149</u>		PRIMARY REG. DIST. NO. <u>1002</u>		Registrar's No. <u>4591</u>	
1. PLACE OF DEATH a. COUNTY <u>Jackson</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Kansas City</u>		c. LENGTH OF STAY (in this place) <u>35 yrs</u>		c. CITY OR TOWN <u>Kansas City</u>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>8437 Park</u>				STREET ADDRESS (If rural, give location) <u>916 8437 Park</u> <span style="float: right;"><u>29690</u></span>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>ROSE</u>		b. (Middle) <u>ZELLIA</u>		c. (Last) <u>WORKMAN</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>10-24-1955</u>	
5. SEX <u>Fe.</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, <input type="checkbox"/> WIDOWED, DIVORCED (Specify) <u>Widowed</u>		8. DATE OF BIRTH <u>5-15-1867</u>	9. AGE (in years last birthday) <u>88</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>at home</u>		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (City and State or Foreign Country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13a. FATHER'S NAME <u>William Anderson</u>			13b. MOTHER'S MAIDEN NAME <u>Martha Jane Makin</u>		14. NAME OF HUSBAND OR WIFE <u>W. M. Workman</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Jane Farnsworth K. C., Mo.</u>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  <i>*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>		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Hemorrhage</u>  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Senile Arteriosclerosis</u> DUE TO (c) <u>Patient Fell From bed Twice hitting head on Floor.</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Sexuality</u>				INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u>  <u>E90-21</u>	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? YES <input 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.) <u>Home</u>		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>Kansas City Jackson, mo</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>10-1-55</u> m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>fell out of bed</u>			
22. I hereby certify that I attended the deceased from <u>10-2-1955</u> , to <u>10-24, 1955</u> , that I last saw the deceased alive on <u>10-24, 1955</u> , and that death occurred at <u>7:30 p.m.</u> from the causes and on the date stated above.							
23a. SIGNATURE <u>Friedman Weinberg</u> (Degree or title) <u>Dr Friedman Weinberg MD</u>				23b. ADDRESS <u>704 Prospect</u>		23c. DATE SIGNED <u>10/25/55</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>10/26/1955</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park Cem</u>		24d. LOCATION (City, town, or county) (State) <u>K. C., Mo.</u>	
DATE REC'D BY LOCAL REG. <u>10-25-55</u>		REGISTRAR'S SIGNATURE <u>Neve Marshall</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>E. K. George &amp; Sons Grandview, MO</u>			

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

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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 Richard E. George

Licensed Embalmer No. 395

P. O. Address Bellon, N.

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.