

FILED DEC 6 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **36982**

BIRTH NO. _____ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. 4950

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 town or township) Kansas City		c. CITY OR TOWN Kansas City	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. LENGTH OF STAY (In this place) 58 yrs.		e. STREET ADDRESS (If rural, give location) 5337 Charlotte	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Mary's Hospital			

3. NAME OF DECEASED (Type or Print) a. (First) Joseph	b. (Middle) A	c. (Last) Raef	4. DATE OF DEATH (Month) 11 (Day) 14 (Year) 55
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5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, / WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 11-25-1896	9. AGE (In years last birthday) 58	IF UNDER 1 YEAR: Months _____ Days _____	IF UNDER 10 HRS: Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Construction Supervisor	10b. KIND OF BUSINESS OR INDUSTRY Standard Oil Co	11. BIRTHPLACE (City and State or Foreign Country) Kansas City, Missouri	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME Aloysius I. Raef	13b. MOTHER'S MAIDEN NAME Elizabeth Weber	14. NAME OF HUSBAND OR WIFE Madie Raef
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year of dates of service) Yes World War I	16. SOCIAL SECURITY NO. 487-10-0754	17. INFORMANT'S SIGNATURE OR NAME Mrs. Madie L. Raef	ADDRESS 5337 Charlotte
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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.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 30 hours
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute Peritonitis		Unknown 30 hours Eyes
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Carcinoma Sigmoid Colon Rupture of Colon - traumatic surgery DUE TO (c) Adhesion of Transverse Colon		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			153X

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION Rupture of Colon; Carcinoma Sigmoid Colon.	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)
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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?
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22. I hereby certify that I attended the deceased from Aug, 1951, to 11/20, 1955, that I last saw the deceased alive on 14 Nov, 1955, and that death occurred at 6:20 pm., from the causes and on the date stated above.

23a. SIGNATURE Fred H. Lundgren Jr. (Degree or title) Fred H. Lundgren Jr. M.D.	23b. ADDRESS 315 Euclid Road	23c. DATE SIGNED 15 Nov 55
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 11-17-55	24c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery	24d. LOCATION (City, town, or county) (State) Kansas City, Missouri
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DATE REC'D BY LOCAL REG. 11-15-55	REGISTRAR'S SIGNATURE Merna Marshall	25. FUNERAL DIRECTOR'S SIGNATURE Melody-McGilley-Eylar	ADDRESS 1800 E. Linwood
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WRITE PLAINLY—USING UNFAADING BLACK INK—MAKE A PERMANENT RECORD

*Dr. Lundgren
Chgo. Ill.*

va 88 3 3

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 *Melvin D. Barton*

Licensed Embalmer No. *499*

P. O. Address *H C Ma*

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.