

40502

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

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

5179

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Mo.</b> b. COUNTY <b>Jackson</b>		
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Kansas City</b>		c. LENGTH OF STAY (in this place) <b>Life</b>	c. CITY OR TOWN <b>Kansas City</b>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Lindeman Nursing Home</b>			STREET ADDRESS (If rural, give location) <b>4021 Campbell St.</b>		
3. NAME OF DECEASED (Type or Print) a. (First) <b>Miss Helen</b> b. (Middle) <b>Mary</b> c. (Last) <b>Deister</b>			4. DATE OF DEATH (Month) (Day) (Year) <b>Nov. 28, 1955</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, <input type="checkbox"/> WIDOWED, DIVORCED (Specify) <b>Single</b>	8. DATE OF BIRTH <b>July 18, 1903</b>	9. AGE (In years last birthday) <b>52 years</b>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housekeeper</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>	11. BIRTHPLACE (City and State or Foreign Country) <b>Kansas City, Mo.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13a. FATHER'S NAME <b>Albert Deister</b>		13b. MOTHER'S MAIDEN NAME <b>Bridget</b>		14. NAME OF HUSBAND OR WIFE -----	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	16. SOCIAL SECURITY NO. <b>none</b>	17. INFORMANT'S SIGNATURE OR NAME <b>J.B.</b> <b>Mrs. Lovett</b>		ADDRESS <b>5414 Charlotte, K.C. Mo.</b>	
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.	MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Hepatic Coma &amp; anemia</b> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Cirrhosis of Liver (Lanceus type) (nutritional)</b> DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH <b>10 days</b> <b>3+ years</b> <b>5811</b>
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION <b>Abdominal Paracentesis - drainage</b>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office, hotel, room)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)			
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?			
22. I hereby certify that I attended the deceased from <b>1-7, 1943</b> , to <b>11-28, 1955</b> , that I last saw the deceased alive on <b>11-28, 1955</b> , and that death occurred at <b>9:49 a.m.</b> , from the causes and on the date stated above.					
23a. SIGNATURE <b>Frank B. Leitz</b> (Degree or title) <b>MD</b>			23b. ADDRESS <b>1530 Pry. Bldg. Kansas City, Mo.</b>		23c. DATE SIGNED <b>11-29-55</b>
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24b. DATE <b>Nov. 30, 1955</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Calvary</b>		24d. LOCATION (City, town, or county) (State) <b>K.C. Mo.</b>	
DATE REC'D BY LOCAL REG. <b>11-29-55</b>	REGISTRAR'S SIGNATURE <b>Neal Marshall</b>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Thos. E. Quirk 4316 Troost K.C. Mo.</b>		

(Licensed Embalmer's Statement on Reverse Side)

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

FILED DEC 28 1955

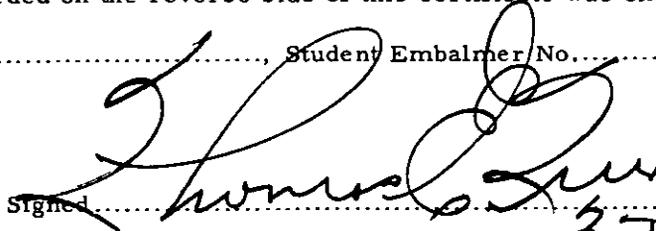
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STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was em  
by me, or by ..... Student Embalmer No. ....  
working under my personal supervision..

Student .....  
Signature of Student Embalmer

Signed  .....

Licensed Embalmer No. ....

P. O. Address .....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. ( 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.