

FILED OCT 31 1956

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 33097

BIRTH NO. _____		REG. DIST. NO. 27		PRIMARY REG. DIST. NO. 5082		Registrar's No. 145	
1. PLACE OF DEATH a. COUNTY BATES				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). --a. STATE KANSAS b. COUNTY WY			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ABRAHAM		c. LENGTH OF STAY (in this place) 5 day		c. CITY OR TOWN KANSAS CITY		d. Is Residence within limits of city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION AUBURN MO RR#3				e. STREET ADDRESS (If rural, give location) 613 CENTRAL AVE			
3. NAME OF DECEASED (Type or Print) a. (First) CONSTAN			b. (Middle) MEHEVICH			c. (Last) MEHEVICH	
4. DATE OF DEATH		5. SEX M		6. COLOR OR RACE WH		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED NEVER MARRIED	
8. DATE OF BIRTH Sept-12-1885		9. AGE (In years last birthday) 71		10. MONTHS 1		11. DAYS 12	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABOR				10b. KIND OF BUSINESS OR INDUSTRY PACKING HOUSE		11. BIRTHPLACE (City and State or Foreign Country) RUSSIA	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13a. FATHER'S NAME ANDREW MEHEVICH		13b. MOTHER'S MAIDEN NAME ANNA		14. NAME OF HUSBAND OR WIFE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/>		16. SOCIAL SECURITY NO. 510-05-7777		17. INFORMANT'S SIGNATURE OR NAME Mrs Joseph Karpint			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Arteriosclerosis		DUE TO (b) Dist 50 + Dist 24 + 956				Inferior	
*This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		DUE TO (c)					
II. OTHER SIGNIFICANT CONDITIONS		Conditions contributing to the death but not related to the disease or condition causing death.					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				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 bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)		4201	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min)		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 Oct 10, 1956, to Oct 24, 1956, that I last saw the deceased alive on Oct 24, 1956, and that death occurred at 4 P. m., from the causes and on the date stated above.							
23a. SIGNATURE E. E. Robinson M.D.				23b. ADDRESS Abraham Mo		23c. DATE SIGNED 10 24 56	
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE Oct 24-56		24c. NAME OF CEMETERY OR CREMATORY HIGHLAND PARK CEM		24d. LOCATION (City, town, or county) (State) KANSAS CITY KANS.	
DATE REC'D BY LOCAL REG. Oct. 26-56		REGISTRAR'S SIGNATURE Kendall Kersey		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Jos A Buller's Sons K C Mo			

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING 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... *Russell W. Dennis* .....

Licensed Embalmer No... *3460* .....

P. O. Address... *K. C. Kas.* .....

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.