

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

36152  
STATE FILE NUMBER  
4840

FILED NOV 5 1957

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4840

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Jackson</b>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kansas City</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Kansas City</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Menorah Medical Center</b>		Length of stay in lb <b>2 yrs</b>	d. STREET ADDRESS (If outside, give location) <b>19 E. Winthrop Rd.</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Julius</b> Middle Last <b>Solomon</b>			4. DATE OF DEATH Month <b>10</b> Day <b>17</b> Year <b>57</b>		
5. SEX <b>D</b> <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11-24-78</b>		9. AGE (In years last birthday) <b>78</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>retired buyer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>dept. store</b>	11. BIRTHPLACE (City and state or country) <b>Aurora, Cook, Ill.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>
13a. FATHER'S NAME <b>Morris Solomon</b>		13b. MOTHER'S MAIDEN NAME <b>Lena Silver</b>		14. NAME OF HUSBAND OR WIFE <b>Paulene Livingston</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>358-03-5326-A</b>		17. INFORMANT Address. <b>Mr. Richard Wolf Chicago, Ill.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> DUE TO (b) <b>Fractured left hip</b> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Cerebral Arteriosclerosis</b>				INTERVAL BETWEEN ONSET AND DEATH <b>1 month</b> <b>5 weeks</b> <b>E9037-44</b>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT <input checked="" type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <b>fell on floor</b>		20c. TIME OF INJURY Hour _____ a.m. _____ p.m. <b>10-11-57</b>			
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Conv. Home</b>		20f. CITY, TOWN, OR LOCATION COUNTY STATE <b>Kansas City Jackson Mo.</b>	
21. I attended the deceased from <b>Oct 1956</b> to <b>Oct 17, 1957</b> and last saw him <b>alive on Oct 17, 1957</b> Death occurred at <b>1:15 P.M.</b> on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <b>John W. Wolf M.D.</b>			22b. ADDRESS <b>409 E. 63 Kansas City, Mo</b>		22c. DATE SIGNED <b>10/17/57</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>10-19-57</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Rosehill (Chicago)</b>		23d. LOCATION (City, town, or county) (State) <b>Chicago Cook Illinois</b>
24. FUNERAL DIRECTOR, ADDRESS <b>J.P. Louts Funeral Home K.C. Mo.</b>			25. DATE RECD. BY LOCAL REG. <b>10-19-57</b>		26. REGISTRAR'S SIGNATURE <b>Neva Marshall</b>

(Licensed Embalmer's Statement on Reverse Side)

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION  
Jack W. Wolf

10-11  
Em 1-0724



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 *Bry Buffington* .....

Licensed Embalmer No. *2754* .....

P. O. Address *N.C. Mo.* .....

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.