

FILED NOV 20 1957

STANDARD CERTIFICATE OF DEATH

40555  
STATE FILE NUMBER  
5100

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 5100

S. 300  
v. 1-57

|  |                                  |   |  |  |  |  |   |                                |
|--|----------------------------------|---|--|--|--|--|---|--------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Jackson</b>  |                                  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Missouri</b> b. COUNTY <b>Jackson</b> |  |  |   |                                |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <b>Kansas City</b>  |                                  | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  |  | c. CITY OR TOWN <b>Kansas City</b>   |  | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |   |                                |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <b>Menorah Medical Center</b>   |                                  |   | Length of stay in lb<br><b>4 1/2 years</b>   |  | d. STREET ADDRESS<br><b>4207 Independence Ave.</b>   |  | Reside on Farm<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>             |                                |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Nannie</b> Middle <b>Lee</b> Last <b>Precht</b>  |                                  |   |  | 4. DATE OF DEATH<br>Month <b>Oct.</b> Day <b>31</b> Year <b>1957</b>   |  |  |   |                                |
| 5. SEX<br><b>Female</b>  | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>10-28-85</b>  |  | 9. AGE (In years last birthday)<br><b>72</b>   | IF UNDER 1 YEAR<br>Months Days  | IF UNDER 24 HRS.<br>Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>House Wife</b>   |                                  |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Domestic</b>   |  | 11. BIRTHPLACE (City and state or country)<br><b>Andrain Co., Missouri</b>                 |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |                                |
| 13a. FATHER'S NAME<br><b>Lee STUART</b>  |                                  |   | 13b. MOTHER'S MAIDEN NAME<br><b>Rose STUART</b>  |  |  | 14. NAME OF HUSBAND OR WIFE<br><b>George F. Precht</b>                               |   |                                |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>No</b>  |                                  |   | 16. SOCIAL SECURITY NO.<br><b>NONE</b>   |  | 17. INFORMANT<br><b>George F. Precht</b> Address <b>4207 Independence Ave. Rte. 4, Mo.</b> |  |   |                                |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarction</b>   |                                  |   |  |  |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>3 days</b>   |                                |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.<br>DUE TO (b) <b>Arterio-sclerotic Heart Disease</b>  |                                  |   |  |  |  |  | <b>11-5</b>   |                                |
| DUE TO (c) <b>Hypertension</b>   |                                  |   |  |  |  |  | <b>11-5</b>   |                                |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)<br><b>4200</b>   |                                  |   |  |  |  |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                |
| 20a. ACCIDENT <input 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.) |  |  |  |   |                                |
| 20c. TIME OF INJURY<br>Hour Month, Day, Year<br>a.m. p.m.  |                                  |   |  |  |  |  |   |                                |
| 20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |                                  | 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |  | 20f. CITY, TOWN, OR LOCATION   |  | COUNTY   |   | STATE                          |
| 21. I attended the deceased from <b>1948</b> to <b>10-31-57</b> and last saw her <b>live on 10-31-57</b><br>Death occurred at <b>12:45 P.</b> m on the date stated above; and to the best of my knowledge, from the causes stated. |                                  |   |  |  |  |  |   |                                |
| 22a. SIGNATURE (Degree or title)<br><b>B. Marcus Heller, M.D.</b>  |                                  |   |  |  | 22b. ADDRESS<br><b>409 E. 63rd</b>   |  | 22c. DATE SIGNED<br><b>10-31-57</b>   |                                |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>   |                                  | 23b. DATE<br><b>Nov. 2, 1957</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>MT. WASHINGTON</b>                                  |  |  | 23d. LOCATION (City, town, or county) (State)<br><b>KANSAS CITY, MISSOURI</b>        |   |                                |
| 24. FUNERAL DIRECTOR<br><b>DW. NONCOMER'S SONS</b> ADDRESS <b>1331 Brush Creek Rte. Mo.</b>  |                                  |   |  | 25. DATE RECD. BY LOCAL REG.<br><b>11-1-57</b>   |  | 26. REGISTRAR'S SIGNATURE<br><b>Neva Trinchell</b>                                   |   |                                |

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

B. Marcus Heller



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 *Edward M. Stone* .....

Licensed Embalmer No. *4452*  
P. O. Address... *K. C. 10 M* .....

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.