

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

1226
STATE FILE NUMBER

FILED JAN 27 1958

Registration District No. 149 Primary Registration District No. 1002 Registrar No. 34

1. PLACE OF DEATH a. COUNTY <u>JACKSON</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY <u>JACKSON</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>KANSAS CITY</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>KANSAS CITY</u> 3428 Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>MEMORAH MEDICAL CENTER 2014</u>		Length of stay in 1b	d. STREET ADDRESS <u>2901 FOREST</u> (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>DON</u> Middle _____ Last <u>EDMONDS</u>			4. DATE OF DEATH Month <u>JAN.</u> Day <u>3.</u> Year <u>1958</u>
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> 3 DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>7-13-01</u>
9. AGE (In years, last birthday) <u>56</u>		IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SALES</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>PHOTOGRAPHY</u>	11. BIRTHPLACE (City and state or country) <u>OSKALOOSA, KANSAS</u>
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13a. FATHER'S NAME <u>THOMAS EDMONDS</u>	
13b. MOTHER'S MAIDEN NAME <u>KATHERINE FAIRHOLM</u>		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) <u>NO</u>		16. SOCIAL SECURITY NO. <u>486-03-3892</u>	
17. INFORMANT <u>HAROLD D. EDMONDS</u>		Address <u>5901 GLADSTONE BLDG. KANSAS CITY MISSOURI</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>myocardial infarction</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Coronary atherosclerosis, severe</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>none</u>			INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u> <u>4201</u>
19. WAS AUTOPSY PERFORMED? 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 Hour _____ Month, Day, Year _____ a.m. _____ p.m. _____	
20d. INJURY OCCURRED WHILE AT WORK <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 <u>7-24-57</u> to <u>1/3/58</u> and last saw him alive on <u>1/3/58</u> Death occurred at <u>10:50</u> a.m. on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>Alexander Shifrin M.D.</u> (Degree or title)		22b. ADDRESS <u>701 East 63rd St. K.C. 10, Mo.</u>	
22c. DATE SIGNED <u>1/3/58</u>		23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	
23b. DATE <u>JAN. 6. 1958</u>		23c. NAME OF CEMETERY OR CREMATORY <u>PLEASANT VIEW CEMETERY</u>	
23d. LOCATION (City, town, or county) <u>BLUE MOUND KANSAS</u>		(State)	
24. FUNERAL DIRECTOR <u>D.W. NEWCOMER'S SONS</u>		ADDRESS <u>1331 BRUSH CREEK KANSAS CITY, MO.</u>	
25. DATE RECD. BY LOCAL REG. <u>1-4-58</u>		26. REGISTRAR'S SIGNATURE <u>neva minshall</u>	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

Alexander Shifrin

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 *Robert Ray*

Licensed Embalmer No. *4182*
P. O. Address *K. 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.