

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-014170
State File No.

FILED MAY 9 1958

2024

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

1. PLACE OF DEATH
a. COUNTY Jackson 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before a. STATE Mo b. COUNTY Jackson (admission).

b. CITY OR TOWN Kansas City c. LENGTH OF STAY (in this place) 49 Mo. c. CITY OR TOWN Kansas City d. Is Residence within limits of a city or incorporated town? Yes No

d. FULL NAME OF HOSPITAL OR INSTITUTION Trinity Lutheran STREET ADDRESS (If rural, give location) 619 W. 13th

3. NAME OF DECEASED a. (First) SAMUEL b. (Middle) _____ c. (Last) FELMAN 4. DATE OF DEATH (Month) (Day) (Year) Apr. 19, 1958

5. SEX M 6. COLOR OR RACE W 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 8. DATE OF BIRTH 9/29/1908 9. AGE (In years last birthday) 49 IF UNDER 1 YEAR Days _____ IF UNDER 1 HR. Hours _____ Min. _____

10a. USUAL OCCUPATION (Give kind of work done during part of working life, even if retired) Produce 10b. KIND OF BUSINESS OR INDUSTRY Self 11. BIRTHPLACE (City and State or Foreign Country) Kansas City, Mo. 12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME Sam Felman 13b. MOTHER'S MAIDEN NAME Lizzie Zeff 14. NAME OF HUSBAND OR WIFE Rose Felman

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) Yes (If yes, give year or dates of service) WW II 16. SOCIAL SECURITY NO. 497-36-5695 17. INFORMANT'S SIGNATURE OR NAME Rose Felman ADDRESS 619 W-13th

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) acute posterior myocardial infarction INTERVAL BETWEEN ONSET AND DEATH 12 hrs.

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death. ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. 4231

19a. DATE OF OPERATION _____ 19b. MAJOR FINDINGS OF OPERATION _____ 20. AUTOPSY? YES NO

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) _____

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) _____ 21e. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK 21f. HOW DID INJURY OCCUR? _____

22. I hereby certify that I attended the deceased from 4-19, 1958, to 4-19, 1958, that I last saw the deceased alive on 4-19, 1958, and that death occurred at 10:40 P.M., from the causes and on the date stated above.

23a. SIGNATURE Wilson H. Miller, M.D. (Degree or title) 23b. ADDRESS 4620 Indep. Ave Kansas City, Mo. 23c. DATE SIGNED 4-20-58

24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL 24b. DATE 4-20-58 24c. NAME OF CEMETERY OR CREMATORY SHEFFIELD CEMETERY 24d. LOCATION (City, town, or county) (State) KANSAS CITY, MO.

DATE REC'D BY LOCAL REG. 4-20-58 REGISTRAR'S SIGNATURE neva Minshall 25. FUNERAL DIRECTOR'S SIGNATURE J.P. LOUIS FUNERAL HOME, K.C. MO. ADDRESS _____

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD
Wilson H. Miller



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 *Henry Buffington*
Licensed Embalmer No. *2751*

P. O. Address *N.C. 276*

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.