

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-044412

STATE FILE NUMBER  
5982

FILED JAN 5 1959

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

S. 300  
1-57

1. PLACE OF DEATH a. COUNTY <i>Jackson</i>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) <i>Missouri</i> STATE COUNTY <i>Jackson</i>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>Kansas City</i>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <i>Kansas City</i>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>Home for Jewish Aged</i>		Length of stay in 1b <i>70 Yrs</i>	d. STREET ADDRESS <i>7801 Holmes</i>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <i>ALTA STEINERT</i>			4. DATE OF DEATH Month Day Year <i>Dec, 15 1958</i>		
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> 2 DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>APPROX.</i>		9. AGE (In years last birthday) <i>81</i> 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) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>	11. BIRTHPLACE (City and state or country) <i>New York City, N.Y.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13a. FATHER'S NAME <i>Louis Cohn</i>		13b. MOTHER'S MAIDEN NAME <i>Unknown</i>		14. NAME OF HUSBAND OR WIFE <i>Israel Steinert</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <i>NO</i>		16. SOCIAL SECURITY NO. <i>-----</i>	17. INFORMANT Address <i>Mrs. Edward Wolberg 9311 Canterbury</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Bronchopneumonia</i>					INTERVAL BETWEEN ONSET AND DEATH <i>1 week</i>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <i>Uremia</i>					<i>3 weeks</i>
DUE TO (c) <i>Arteriosclerotic Cardiovascular Disease</i>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>Parkinson's Disease</i>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <i>1</i>
20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I of PART II of item 18.) <i>U.S.A.</i>		
20c. TIME OF INJURY Hour Month, Day, Year 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 <i>1955</i> to <i>12-15-1958</i> and last saw <sup>her</sup> <sub>him</sub> alive on <i>12-9-58</i> Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Dress or title) <i>Harry K. Cohen M.D.</i>			22b. ADDRESS <i>751 E. 63rd St</i>		22c. DATE SIGNED <i>12-16-58</i>
23a. BURIAL, CREMATION REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>Dec. 17 1958</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Elmwood Cemetery</i>		23d. LOCATION (City, town, or county) (State) <i>Kansas City, Missouri</i>
24. FUNERAL DIRECTOR ADDRESS <i>J.P. Louis Funeral Home K.C.Mo.</i>			25. DATE RECD. BY LOCAL REG. <i>12-17-58</i>	26. REGISTRAR'S SIGNATURE <i>Irene Marshall</i>	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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.

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 *Guy Buffington*  
Licensed Embalmer No. *2756*.....  
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.