

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

001238

59-17-150
STATE FILE NUMBER

FILED FEB 5 1959

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 396

300
-57

1. PLACE OF DEATH a. COUNTY JACKSON		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Jackson	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN KANSAS CITY Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN Kansas City Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Downtown Hosp.		d. STREET ADDRESS (If outside, give location) 1413 Summitt Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MIKE Middle J. Last CINDRICH		4. DATE OF DEATH Month Day Year Jan. 20, 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-26-1890
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. R. R. Carman		10b. KIND OF BUSINESS OR INDUSTRY Railroad	11. BIRTHPLACE (City and state or country) Yugoslavia
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13a. FATHER'S NAME Unknown	
13b. MOTHER'S MAIDEN NAME Unknown		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) No		16. SOCIAL SECURITY NO. 509-09-5406	17. INFORMANT Address Joseph Shullak, K. C. Mo.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis with left Hemiplegia Conditions, if any, which gave rise to above cause (a), stating the underlying cause lost. } DUE TO (b) Cerebral Arteriosclerosis DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH 3 days Unknown
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Hematemesis-Terminal; Etiology Undetermined.			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 <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 11-6-1958 to 1-20-1959 and last saw him alive on 1-20-1959 Death occurred at 6 P.M. m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>J. Multhauf</i> (Degree or title) M.D.		22b. ADDRESS 1222 McGee St., K.C., Mo.	
22c. DATE SIGNED 1-22-59			
23a. BURIAL, CREMATION, OR REMOVAL (Specify) Removal		23b. DATE 1-20-1959	
23c. NAME OF CEMETERY OR CREMATORY Mt. Calvary		23d. LOCATION (City, town, or county) (State) Kansas City, Kansas	
24. FUNERAL DIRECTOR ADDRESS Skradski - Stine F. H. K. C. K.		25. DATE RECD. BY LOCAL REG. 1-22-59	
		26. REGISTRAR'S SIGNATURE <i>Neva Marshall</i>	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

C. J. Multhauf

Doctor, coroner, etc. must use only standard nomenclature in their report. No symptoms will be treated. 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 *W. H. Kradich*

Licensed Embalmer No. 4382
P. O. Address R. C. K.

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.