

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-017576

STATE FILE NUMBER

FILED JUN 9 1959

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 2511

300  
1-57 0

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, MO		c. CITY OR TOWN KANSAS CITY, MO	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION GENERAL HOSPITAL		d. STREET ADDRESS 1213 Illinois	
3. NAME OF DECEASED (Type or print) First Middle Last Henry Thomas Alnutt		4. DATE OF DEATH Month Day Year 5-20-59	
5. SEX M	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-15-03
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer		9b. KIND OF BUSINESS OR INDUSTRY Theatre	9c. AGE (In years last birthday) 55
10a. FATHER'S NAME Thomas Alnutt		10b. MOTHER'S MAIDEN NAME Cora Runyan	10c. NAME OF HUSBAND OR WIFE Rose Alnutt
11. BIRTHPLACE (City and state or country) Chillicothe, Mo		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		14. SOCIAL SECURITY NO. 329-05-2321	15. INFORMANT Mrs. Rose Alnutt
16. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage from G.I. tract		INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Possible Cirrhosis, Laennec's			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		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 5-20-59 to 5-20-59 and last saw her alive on 5-20-59 Death occurred at 2:30 PM on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE Abraham Gelperin M.D.		22b. ADDRESS General Hospital	22c. DATE SIGNED 5-20-59
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE May-20-1959	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or county) (State) Chillicothe, Mo
24. FUNERAL DIRECTOR C. H. Blackman San Inc. K.C. Mo		25. DATE RECD. BY LOCAL REG. 5-21-59	26. REGISTRAR'S SIGNATURE Neva Marshall

All diseases in Part I must be causally related.

Abraham Gelperin USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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. O. Perrine* .....

Licensed Embalmer No. *4879* .....

P. O. Address *H.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.