

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-021626

STATE FILE NUMBER

FILED JUN 24 1959

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 2886

300
1-57

1. PLACE OF DEATH a. COUNTY <i>Jackson</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Mo</i> b. COUNTY <i>Jackson</i>	
b. CITY (If not a corporate limits, give TOWNSHIP only) <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) <i>St Mary's Hosp</i>		Length of stay in 1b <i>40 yrs</i>	d. STREET ADDRESS (If possible, give location) <i>2746 Bellview</i>
HOSPITAL OR INSTITUTION		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) <i>Don J. Perez</i>			4. DATE OF DEATH Month <i>6</i> Day <i>13</i> Year <i>59</i>			
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5. SEX <i>Male</i>	6. COLOR OR RACE <i>Mex</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>9-10-1898</i>	9. AGE (In years last birthday) <i>60</i>	10. F UNDER 1 YEAR Months <i>0</i> Days <i>0</i> Hours <i>0</i> Min. <i>0</i>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Labour</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>M.P.R.R</i>	11. BIRTHPLACE (City and state or country) <i>Mexico</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>
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13a. FATHER'S NAME <i>Juan Perez</i>	13b. MOTHER'S MAIDEN NAME <i>Sauline Hernandez</i>	14. NAME OF HUSBAND OR WIFE <i>2845</i>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>No</i>	16. SOCIAL SECURITY NO. <i>353-09-5696</i>	17. INFORMANT <i>Mrs Josephine Sanchez</i>	Address <i>Bellview</i>
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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>Coronary thrombosis</i>		INTERVAL BETWEEN ONSET AND DEATH <i>12 hrs</i>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <i>arteriosclerotic heart disease</i> DUE TO (c) <i>9 mos.</i>		
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.) <i>4200</i>
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20c. TIME OF INJURY Hour <i>4:00</i> a.m. <i>0</i> p.m. <i>0</i>	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION <i>4200</i>	COUNTY	STATE
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21. I attended the deceased from <i>11-1-58</i> , to <i>6-13-59</i> and last saw him alive on <i>6-13-59</i> Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE <i>Graham Owens M.D.</i>	(Degree or title) <i>M.D.</i>	22b. ADDRESS <i>906 Grand</i>	22c. DATE SIGNED <i>6-14-59</i>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE <i>6-15-59</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Not St Marys</i>	23d. LOCATION (City, town, or county) (State) <i>KC Mo</i>
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24. FUNERAL DIRECTOR <i>Walter J. Logelma</i>	ADDRESS <i>Ke-mo</i>	25. DATE RECD. BY LOCAL REG. <i>6-14-59</i>	26. REGISTRAR'S SIGNATURE <i>neva minshall</i>
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Graham Owens

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 *John B. Legatna*

Licensed Embalmer No. *4273*

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.