

DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-024959

FILED VS AUG 10 1959

3519

STATE FILE NUMBER

Registration District No. 249 Primary Registration District No. 1002 Registrar's No.

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		Length of stay in 1b 78 YRS.		c. CITY OR TOWN KANSAS CITY		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 1215 ROMANY RD.			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 1215 ROMANY RD.		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ISIDOR Middle A. ADLER Last				4. DATE OF DEATH Month JULY Day 20 Year 1959				
5. SEX MALE	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 ABRIL 7 1875	9. AGE (last birthday) 84 YRS.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ADLERS			10b. KIND OF BUSINESS OR INDUSTRY Sub. Store	11. BIRTHPLACE (City and state or country) GERMANY		12. CITIZEN OF WHAT COUNTRY USA		
13a. FATHER'S NAME ANSEL ADLER			13b. MOTHER'S MAIDEN NAME UNKNOWN			14. NAME OF HUSBAND OR WIFE MAE ADLER		
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. 493 30 2073		17. INFORMANT Address MAE ADLER 1215 ROMANY RD. 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) Encephalomalacia - Brain Stem (Basilar)						INTERVAL BETWEEN ONSET AND DEATH 3 mos.		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Cerebral Thrombosis - Basilar						"		
DUE TO (c) Cerebral Atherosclerosis						"		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 1.) Bronchopneumonia 2.) Pylonephritis 3.) Malnutrition						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input 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 a.m. p.m. Month, Day, Year								
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 Feb. 1956 to 20 July 1959 and last saw ^{her} _{him} alive on 20 July 1959 Death occurred at 9:45 A.M. on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) Philip G. Kaul M.D.				22b. ADDRESS 411 Nichols Road		22c. DATE SIGNED 20 July 59.		
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE JULY 21, 1959	23c. NAME OF CEMETERY OR CREMATORY ROSEHILL CEM		23d. LOCATION (City, town, or county) KANSAS CITY, MO.		23e. (State)		
24. FUNERAL DIRECTOR D. W. Newcomer's Sons MO				25. DATE RECD. BY LOCAL REG. 7-20-59	26. REGISTRAR'S SIGNATURE neva Minshall			

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF Philip G. Kaul I

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____, Student Embalmer No. _____, or by _____, Student Embalmer No. _____, working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Albert H. Savage

Licensed Embalmer No. 4812

P. O. Address Kansas City

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to do so 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.