

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-025525

JUL 17 1959

149

1002

3330

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

DEED

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 17 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 General Hospital		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 3126 Forest Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Frances Middle Yeager Last Yeager	4. DATE OF DEATH Month 7 Day 5 Year 59
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5. SEX Female	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH APRIL 21, 1880	9. AGE (last birthday) 79 YRS.	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MACY'S SEAMSTRESS	10b. KIND OF BUSINESS OR INDUSTRY Dept. Store	11. BIRTHPLACE (City and state or country) EDGERTON, MO.	12. CITIZEN OF WHAT COUNTRY USA
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13a. FATHER'S NAME GEORGE GWINN	13b. MOTHER'S MAIDEN NAME, M. HARRIET GWINN	14. NAME OF HUSBAND OR WIFE OSCAR YEAGER
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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) NO	16. SOCIAL SECURITY NO. UNKNOWN	17. INFORMANT MRS. G. L. LAMBERT 3126 FOREST, Address
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18. CAUSE OF DEATH (Enter only one cause per Part I or Part II) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Arteriosclerotic heart disease	
	DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		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.)
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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 _____
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21. I attended the deceased from **6-9-59** to **7-5-59** and last saw her **alive** or **7-5-59**
Death occurred at **8:21 A.M.** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Abraham Gelperin	22b. ADDRESS 2400 Cherry	22c. DATE SIGNED 7-7-59
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23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE JULY 7, 1959	23c. NAME OF CEMETERY OR CREMATORY FOREST HILL CEM	23d. LOCATION (City, town, or county) (State) KANSAS CITY, MO.
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24. FUNERAL DIRECTOR D.W. Newcome's Son. Mo. ADDRESS	25. DATE RECD. BY LOCAL REG. 7-7-59	26. REGISTRAR'S SIGNATURE Heva Trinaloff
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DOCUMENT

BY AFFIDAVIT OF Abraham Gelperin, M.D. 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
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed _____

Licensed Embalmer No. _____

P. O. Address _____

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.