

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-032473

FILED VS SEP 25 1959 149

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4461 STATE FILE NUMBER

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 2 weeks	c. CITY OR TOWN Kansas City 23 Inside Limits Yes <input checked="" 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 checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 32y So. Drury Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Fred Middle Ross Last Martin			4. DATE OF DEATH Month 9 Day 13 Year 59			
5. SEX male	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 5-9-1888	9. AGE (last birthday) 71	IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired cleaner & presser		10b. KIND OF BUSINESS OR INDUSTRY Cleaning	11. BIRTHPLACE (City and state or country) Ohio	12. CITIZEN OF WHAT COUNTRY USA		
13a. FATHER'S NAME Oscar W. Martin		13b. MOTHER'S MAIDEN NAME Sara A. Davidson		14. NAME OF HUSBAND OR WIFE OPal M. Martin (deceased)		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 379-09-7477A	17. INFORMANT Address Grace Woodman 329 So. Drury K.C. 23			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) Cardiac Arrest		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Congestive 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) compression fracture of hip		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 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 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 **8-31-59** to **9-13-59** and last saw him alive on **9-13-59**
Death occurred at **1:45 P** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Abraham Gelperin M.D.		22b. ADDRESS 2400 Cherry		22c. DATE SIGNED 9-14-59
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	23b. DATE 9-15-59	23c. NAME OF CEMETERY OR CREMATORY Elmwood Cemetery	23d. LOCATION (City, town, or county) (State) Kansas City, Missouri	
24. FUNERAL DIRECTOR Geo. C. Carson & Sons Indep., Mo		25. DATE RECD. BY LOCAL REG. 9-14-59	26. REGISTRAR'S SIGNATURE Neva Marshall	

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 Dean W Huff

Licensed Embalmer No. 4914

P. O. Address endless m

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.