

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH 59-032533

FILED VS OCT 7 1959

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4525 STATE FILE NUMBER

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY <b>Jackson</b>	a. STATE <b>Missouri</b>		b. COUNTY <b>Jackson</b>
b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kansas City</b>	Length of stay in 1b <b>48 yrs.</b>	c. CITY OR TOWN <b>Kansas City</b>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>2319 Monitor Place</b>		d. STREET ADDRESS <b>2319 Monitor Place</b>	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print)			4. DATE OF DEATH		
First <b>GUADALUPE</b>	Middle <b>- (PRIMOZIC)</b>	Last <b>PRIMZIC</b>	Month <b>9</b>	Day <b>16</b>	Year <b>59</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>11-26-84</b>	9. AGE (last birthday) <b>74</b>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	11. BIRTHPLACE (City and state or country) <b>Cuernavaca, Mexico</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>
13a. FATHER'S NAME <b>Manuel Gallegos</b>		13b. MOTHER'S MAIDEN NAME <b>Julita Rueda</b>		14. NAME OF HUSBAND OR WIFE <b>Matias Primzic</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT Address <b>John W.F. Deister: RR#5 Parkville, Mo.</b>		

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 <b>Aug 27/59</b>
IMMEDIATE CAUSE (a)	<b>Coronary occlusion</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	<b>Hypertensive Cardiac-vascular disease</b>	
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 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 <b>July 21/59</b> to <b>Sept 15/59</b> and last saw her <b>Sept 15/59</b> alive on <b>Sept 15/59</b> Death occurred at _____ m on the date stated above, and to the best of my knowledge from the causes stated.			
22a. SIGNATURE (Deceased or title) <b>Heidi Prime MD</b>		22b. ADDRESS <b>715 Westport Road</b>	22c. DATE SIGNED <b>9/16/59</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>9-18-59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mount Saint Mary's</b>	23d. LOCATION (City, town, or county) <b>Kansas City Missouri</b>
24. FUNERAL DIRECTOR <b>WEILERT FUNERAL HOMES (W) K.C., MO.</b>		25. DATE RECD. BY LOCAL REG. <b>9-17-59</b>	26. REGISTRAR'S SIGNATURE <b>Neva Minshall</b>

DOCUMENT MEDICAL CERTIFICATION BY AFFIDAVIT OF NEVADA PRIME

**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 B. E. Weiler

Licensed Embalmer No. 4072

P. O. Address K. C. 8, 7

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