

DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-032627

FILED VS SEP 23 1959

4371

STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4371

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 unk.		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 #1			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 815 Ewing EUCLID			Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First WILLIAM Middle E? Last Trigg William				4. DATE OF DEATH Month 9 Day 6 Year 59			
5. SEX Female	6. COLOR OR RACE Negro	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 11/7/1910	9. AGE (last birthday) 48	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/>	IF UNDER 24 HR Hours <input type="checkbox"/> Min. <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) Missouri	12. CITIZEN OF WHAT COUNTRY U.S.	
13a. FATHER'S NAME Tom Brown			13b. MOTHER'S MAIDEN NAME Unknown		14. NAME OF HUSBAND OR WIFE Carl Trigg		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>		16. SOCIAL SECURITY NO. —		17. INFORMANT Address Edward Adams K.C. Missouri			
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) Myocardial Infarction							
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.							
DUE TO (b) Arteriosclerotic Coronary Thrombosis							
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 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 <input type="checkbox"/> a.m. <input type="checkbox"/> 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 9-5-59 to 9-6-59 and last saw her alive on 9-6-59 Death occurred at 11:10A.M. m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <i>Abraham Gelpert</i> (Degree or title)			22b. ADDRESS General Hospital #1			22c. DATE SIGNED 9-7-59	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 9/9/1959	23c. NAME OF CEMETERY OR CREMATORY Sapington Cemetery		23d. LOCATION (City, town, or county) Arrow Rock Mo.			(State)
24. FUNERAL DIRECTOR Bailey Funeral Home. K.C. Kansas			ADDRESS	25. DATE RECD. BY LOCAL REG. 9-8-59	26. REGISTRAR'S SIGNATURE <i>Irene Marshall</i>		

DOCUMENT

BY AFFIDAVIT OF

Abraham Gelpert, 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 Clifford J. Woods

Licensed Embalmer No. 3106

P. O. Address 1520 7/15

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.