

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-039380

FILED VS. NOV 25 1959 73

Registration District No. _____ Primary Registration District No. 5291 Registrar's No. 128

STATE FILE NUMBER

INDEXED

1. PLACE OF DEATH a. COUNTY Clay				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Kansas b. COUNTY Wyandotte			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Liberty		Length of stay in 1b 2 months		c. CITY OR TOWN Kansas City		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Odd Fellows Home			Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 4311 Parallel			Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last STANLEY DELICH				4. DATE OF DEATH Month Day Year November 15, 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 3-4-1885	9. AGE (last birthday) 74	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) Laborer			10b. KIND OF BUSINESS OR INDUSTRY Meat packing		11. BIRTHPLACE (City and state or country) Yugoslavia		12. CITIZEN OF WHAT COUNTRY U.S.A.
13a. FATHER'S NAME (Unknown) Delich			13b. MOTHER'S MAIDEN NAME Unknown			14. NAME OF HUSBAND OR WIFE Carrie Delich	
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. 510-07-5515		17. INFORMANT Address Mrs. Carrie Delich K.C.K.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Haemorrhage DUE TO (b) Arteriosclerosis DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH hour	
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.)			
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.							
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 Sept 6 to Nov 15 and last saw him alive on Nov 14 Death occurred at _____ p.m. on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) Wm. H. Goodson M.D.				22b. ADDRESS Liberty Mo		22c. DATE SIGNED 11/14/59	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 11-15-1959	23c. NAME OF CEMETERY OR CREMATORY Mt. Calvary		23d. LOCATION (City, town, or county) Kansas City, Kansas		
24. FUNERAL DIRECTOR ADDRESS Skradski - Stine F. H. K C K. Matt Skradski			25. DATE RECD. BY LOCAL REG. 11-21-59		26. REGISTRAR'S SIGNATURE Mabel Graham		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

82 1928 87

STATE OF MISSOURI
DEPARTMENT OF HEALTH
DIVISION OF PUBLIC HEALTH

AS DEC 16 1959

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 Mat Shradick

Licensed Embalmer No. 4382

P. O. Address Kan. City, Mo.

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.