

FURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-040029

FILED VS. NOV 17 1959

STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 5207

UNDECEASED

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 50 yrs	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 General Hospital		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 1705 Summit Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First William Middle Last Emmett	4. DATE OF DEATH Month 10- Day 27 Year 59
---------------------------------------------------------------------------------------	-------------------------------------------------------------------

5. SEX Male	6. COLOR OR RACE white	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 5-18, 1881	9. AGE (last birthday) 78	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR
--------------------	-------------------------------	-------------------------------------------------------------------------------------------------------------------------------------------------------------	---------------------------------------	----------------------------------	-------------------------------------------	----------------

10a. USUAL OCCUPATION (Give kind of work done during most working life, even if retired) Land Lord	10b. KIND OF BUSINESS OR INDUSTRY apt. House	11. BIRTHPLACE (City and state or country) Kansas	12. CITIZEN OF WHAT COUNTRY U.S.A.
--------------------------------------------------------------------------------------------------------------	--------------------------------------------------------	-------------------------------------------------------------	----------------------------------------------

13a. FATHER'S NAME Unknown	13b. MOTHER'S MAIDEN NAME Emmett Louella Hutchins	14. NAME OF HUSBAND OR WIFE None
--------------------------------------	-------------------------------------------------------------	--------------------------------------------

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. 495-24-3173	17. INFORMANT Mr. Helen Wolfe Address 2509 Flankers Dr. Portland
----------------------------------------------------------------------------------------------------------------------	-----------------------------------------------	-----------------------------------------------------------------------------------

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 hemorrhage		INTERVAL BETWEEN ONSET AND DEATH 09
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b)	
	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 10 a.m. 27 Month, Day, Year 1959 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 Kansas City COUNTY STATE
--------------------------------------------------------------------------------------------------------	------------------------------------------------------------------------------------------	-----------------------------------------------------------------

21. I attended the deceased from 10-27-1959 to 10-27-1959 and last saw him alive on 10-27-1959 Death occurred at 10:55 P m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Abraham Gelpert M.D.	22b. ADDRESS 2400 Cherry - Kansas City, Mo	22c. DATE SIGNED 10-28-59
-----------------------------------------------------------------	------------------------------------------------------	-------------------------------------

23a. BURIAL, CREMATION, OR OTHER DISPOSAL buried	23b. DATE 10-30-59	23c. NAME OF CEMETERY OR CREMATORY Calvary	23d. LOCATION (City, town, or county) (State) Kansas City Mo.
------------------------------------------------------------	------------------------------	------------------------------------------------------	-------------------------------------------------------------------------

24. FUNERAL DIRECTOR Melody McElley Cylor ADDRESS main st	25. DATE RECD. BY LOCAL REG. 10-29-59	26. REGISTRAR'S SIGNATURE Neva Marshall
----------------------------------------------------------------------------	-------------------------------------------------	---------------------------------------------------

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

BY AFFIDAVIT OF Abraham Gelpert, M.D. - Death Certification

1927/07/06

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me
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.