

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS OCT 27 1960

60-038261

5037

STATE FILE NUMBER

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

1. PLACE OF DEATH a. COUNTY <i>Jackson</i>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MO</i> b. COUNTY <i>Jackson</i>			
b. CITY (If outside corporate limits, give TOWNSHIP only) <i>Kansas City</i>		Length of stay in lb <i>unk</i>		c. CITY OR TOWN <i>Kansas City</i>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>General Hospital</i>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <i>1118 E 8</i>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>HENRY</i> Middle <i>BARSCH</i> Last				4. DATE OF DEATH Month <i>10</i> - Day <i>1</i> - Year <i>1960</i>			
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <i>6-23-1893</i>	9. AGE (last birthday) <i>67</i>	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) <i>labor</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <i>Minn.</i>		12. CITIZEN OF WHAT COUNTRY <i>USA</i>	
13a. FATHER'S NAME <i>unk</i>			13b. MOTHER'S MAIDEN NAME <i>Elizabeth Barsch</i>			14. NAME OF HUSBAND OR WIFE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <i>yes WW #1</i>		16. SOCIAL SECURITY NO. <i>unk</i>		17. INFORMANT Address <i>Jackson County Welfare KC MO</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pulmonary Embolus</i> DUE TO (b) <i>Fracture of Right Shoulder and</i> DUE TO (c) <i>cells</i> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH
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 checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input checked="" 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.) <i>?</i>			
20c. TIME OF INJURY Hour <i>9</i> - Month, Day, Year <i>12-60</i> a.m. p.m.							
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <i>?</i>		20f. CITY, TOWN, OR LOCATION <i>Kansas City</i>		COUNTY <i>Jackson</i>	STATE <i>MO</i>
21. I attended the deceased from _____ to _____ and last saw her/him alive on _____ Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.							
22. SIGNATURE (Degree or title) <i>Geo. Kealhofer</i>				22b. ADDRESS <i>6627 Grand St. Kansas</i>		22c. DATE SIGNED <i>10-1-60</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal</i>		23b. DATE <i>10-7-60</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Mt Calvary</i>		23d. LOCATION (City, town, or county) (State) <i>Kansas City, Kans.</i>		
24. FUMERAL DIRECTOR <i>Caustentano Bros</i>			ADDRESS <i>KC MO.</i>	25. DATE RECD. BY LOCAL REG. <i>10-7-60</i>	26. REGISTRAR'S SIGNATURE <i>H. L. Dwyer</i>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

2023

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 *[Handwritten Signature]*

Licensed Embalmer No. 4534

P. O. Address KC Mo

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.