

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

AMENDED

235261-012762 STATE FILE NUMBER

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

DATE AMENDED

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

B. Marcus Heller

| | | | | | | | |
|---|--|---|--|--|---|---|---------------------|
| 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 70 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 Menorah Medical Center | | | | d. STREET ADDRESS (If outside, give location) 720 West 48th Street | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Esther Middle Schwartz Last Schwartz | | | 4. DATE OF DEATH Month 5 Day 10 Year 61 | | | | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH 12/29/90 | 9. AGE (last birthday) 70 | IF UNDER 1 YEAR Months 3 Days 10 Hours 15 Min. | IF UNDER 24 HR Hours 15 Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY Home | | 11. BIRTHPLACE (City and state or country) Kansas City, Mo. | | 12. CITIZEN OF WHAT COUNTRY U.S.A. | |
| 13a. FATHER'S NAME Herman Asotsky | | | 13b. MOTHER'S MAIDEN NAME Sarah Shanberg | | 14. NAME OF HUSBAND OR WIFE Morris H. Schwartz | | |
| 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. - | | 17. INFORMANT Address Alvin Schwartz, 825 W. 53rd, K.C., Mo. | | |
| 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 | | | | | | 3 days | |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | | | | | | DUE TO (b) Arterio-sclerotic cardio-vasc. -renal Dis 3 yrs | |
| DUE TO (c) DIABETES, Melitica + Hypertension | | | | | | Yes | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Renal shutdown 2 days - ANGINA Pectoris | | | | | PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" 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 3:15 P. Month, Day, Year 5-10-61 | 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 | | STATE Mo. |
| 21. I attended the deceased from 1946 to 5-10-61 and last saw her alive on 5-10-61 Death occurred at 3:15 P. on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | | |
| 22a. SIGNATURE (Degree or title) B. Marcus Heller, M.D. | | | | 22b. ADDRESS 409 E. 63rd | | 22c. DATE SIGNED 5-12-61 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE 5/12/1961 | 23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery | | 23d. LOCATION (City, town, or county) (State) Kansas City, Mo. | | |
| 24. FUNERAL DIRECTOR ADDRESS J.P. Louts Funeral Home, K.C., Mo. | | | | 25. DATE RECD. BY LOCAL REG. 5-12-61 | | 26. REGISTRAR'S SIGNATURE Ruth Long | |

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 Greg Buffington.

Licensed Embalmer No. ~~200~~ 27

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.