

FILED AUG 12 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

23286
State File No. 3201

48

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

BIRTH NO. _____		REG. DIST. NO. <u>149</u>		PRIMARY REG. DIST. NO. <u>1002</u>		Registrar's No. _____		
1. PLACE OF DEATH a. COUNTY <u>Jackson</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u>				
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Kansas City</u>		c. LENGTH OF STAY (In this place) <u>35 yrs</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Kansas City</u>		18 48		
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>716 Montgall</u>				d. STREET ADDRESS (If rural, give location) <u>716 Montgall</u>				
3. NAME OF DECEASED (Type or Print) a. (First) <u>Alois</u>			b. (Middle) _____		c. (Last) <u>Anne</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>7-23-49</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>		8. DATE OF BIRTH <u>4-18-1883</u>	9. AGE (In years last birthday) <u>66</u>	10. UNDER 1 YEAR Months _____ Days _____	11. UNDER 1 MRS. Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Letter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>St. Joseph Hosp.</u>		11. BIRTHPLACE (State or foreign country) <u>Belgium</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		
13a. FATHER'S NAME <u>Charles Anne</u>			13b. MOTHER'S MAIDEN NAME <u>Ant</u>		14. NAME OF HUSBAND OR WIFE <u>Leontine Anne</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>487-12-23</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mrs. Frank Strack 716 Montgall</u>				
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Hemorrhage</u> INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Arterio Sclerosis</u> DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.						
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <u>351X</u>					20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)				
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?				
22. I hereby certify that I attended the deceased from <u>7/19</u> , 19 <u>49</u> , to <u>7/23</u> , 19 <u>49</u> ; that I last saw the deceased alive on <u>7/23</u> , 19 <u>49</u> , and that death occurred at _____ m., from the causes and on the date stated above.								
23a. SIGNATURE <u>R. A. Williams</u> (Degree or title) <u>D. K. Wellmanes, M.D.</u>				23b. ADDRESS <u>6400 St John Ave K.C. Mo.</u>		23c. DATE SIGNED <u>7/25-49</u>		
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>7/26/49</u>		24c. NAME OF CEMETERY OR CREMATORY <u>St Marys</u>		24d. LOCATION (City, town, or county) (State) <u>Kansas City Mo.</u>		
DATE REC'D BY LOCAL REG. <u>7-25-49</u>		REGISTRAR'S SIGNATURE <u>Geraldine Holman</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>John P. Shiel 15648</u>				

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.

Signed John P. Shiel

Signed _____
Student Embalmer

Licensed Embalmer No. 3625

P. O. Address 116 N. J.

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 this body is not embalmed, fact should be so stated above.