

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

13053

STATE FILE NUMBER

FILED MAY 7 - 1957

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 1836

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Jackson</b>			
b. CITY (If outside corporate limits, give TOWNSHIP only) <b>Kansas City</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <b>Kansas City</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) <b>Trinity Lutheran</b>			Length of stay in lb. <b>40 yrs</b>		d. STREET ADDRESS <b>3926 Brooklyn</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>FAYE</b>				First <b>Minnie</b>		Last <b>COURTER</b>	
4. DATE OF DEATH <b>4 18 57</b>		Month <b>4</b>		Day <b>18</b>		Year <b>57</b>	
5. SEX <b>Fe</b>	6. COLOR OR RACE <b>Wh</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>5-1-1900</b>		9. AGE (In years last birthday) <b>56</b>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (City and state or country) <b>St. Joseph, Mo.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>James A. Halterman</b>				14. MOTHER'S MAIDEN NAME <b>Lula Rice</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yrs, give war or dates of service) <b>No xx</b>		16. SOCIAL SECURITY NO. <b>487-03-8214</b>		17. INFORMANT Address <b>S.A. Courter, 3926 Brooklyn, K.C. Mo</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Thrombosis of Cerebral Artery</b> DUE TO (b) <b>Arteriosclerosis</b> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I:(a) <b>Apoplexy 4 years ago</b>						INTERVAL BETWEEN ONSET AND DEATH <b>10 days</b> <b>10 years +</b> <b>332x</b>	
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 <b>4/8/57</b> to <b>4/18/57</b> and last saw her alive on <b>4/18/57</b> Death occurred at <b>10:10 P.M.</b> on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <b>R.R. Becker M.D.</b>				22b. ADDRESS <b>4000 Baltimore Kansas City, Mo.</b>		22c. DATE SIGNED <b>4/19/57</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>4-20-57</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Forest Hill</b>		23d. LOCATION (City, town, or county) (State) <b>Kansas City Mo.</b>		
24. FUNERAL DIRECTOR <b>Wagner Funeral Home, K.C. Mo</b>			ADDRESS		25. DATE RECD. BY LOCAL REG. <b>4-19-57</b>	26. REGISTRAR'S SIGNATURE <b>Neva Marshall</b>	

(Licensed Embalmer's Statement on Reverse Side)

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

300  
1-56

Health,  
Welfare  
Public  
Service



201-5800  
2 PM

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 *Alvin R. Hauschka*

Licensed Embalmer No. *410*

P. O. Address *Kansas*

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.