

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

13499

STATE FILE NUMBER

FILED MAY 1 - 1957

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 1727

1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)			
a. COUNTY Jackson		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City		a. STATE Missouri		b. COUNTY Jackson	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 3637 Tracy		Length of stay in 1b 6 yrs		c. CITY OR TOWN 638 Kansas City		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)				4. DATE OF DEATH			
First BELLE		Middle WOLZ		Last WOLZ		Month Day Year 4 11 57	
5. SEX Fe	6. COLOR OR RACE Wh	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-7-1865	9. AGE (In years last birthday) 91		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10b. KIND OF BUSINESS OR INDUSTRY XX		11. BIRTHPLACE (City and state or country) Leavenworth, Kansas		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles Davis				14. MOTHER'S MAIDEN NAME Elizabeth West			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No XX		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Miss Ruby Hayden, 3637 Tracy, KC Mo			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Encephalomalacia							INTERVAL BETWEEN ONSET AND DEATH 2 Years.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.							
DUE TO (b) Cerebral thromboses (recurrent)							2 Years.
DUE TO (c) Cerebral Arteriosclerosis							10 Years.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 1) Bronchopneumonia. 2) Hypertension.							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/>		SUICIDE <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 1953 to 11 April 1957 and last saw her alive on 9 April 57 Death occurred at 10:40 P.M. on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) Philip G. Kaul MD.				22b. ADDRESS 411 Nichols Road		22c. DATE SIGNED 12 April 57	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 4-13-57		23c. NAME OF CEMETERY OR CREMATORY Floral Hills Cem.		23d. LOCATION (City, town, or county) (State) Kansas City, Mo.	
24. FUNERAL DIRECTOR ADDRESS Wagner Funeral Home, KC Mo				25. DATE RECD. BY LOCAL REG. 4-13-57		26. REGISTRAR'S SIGNATURE Neva Minshall	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
Philip G. Kaul

8 E 1-12-26

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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 *R. L. Harwood*

Licensed Embalmer No. *373*

P. O. Address *H. L. ...*

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.