

Health,
& Welfare
S. Public
th Service

S. 300
v. 1-57

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

174006
STATE FILE NUMBER
1991

FILED MAY 20 1957

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

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		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	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 Little Sisters of the Life		Length of stay in lb	d. STREET ADDRESS (If outside, give location) 1026 Fuller		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) KATHRYN VOSSEN			4. DATE OF DEATH Month Day Year April 24 1957		
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 9-13-86	9. AGE (In years last birthday) 69 7/8	IF UNDER 1 YEAR Months Days Hours 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 Maurice Mahoney		13b. MOTHER'S MAIDEN NAME Jane Mary Allman		14. NAME OF HUSBAND OR WIFE Joseph A. Vossen	
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. 496-07-8229-B		17. INFORMANT Address Mrs. Edward G. Magers 616 E. 73rd St	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Broncho-pneumonia (Hypostatic) DUE TO (b) Arterio sclerosis DUE TO (c) Osteoporosis 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)				INTERVAL BETWEEN ONSET AND DEATH 2 wks Unknown 4500	
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 <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> 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 12/2/56 to 4/24/57 and last saw her alive on 4/23/57 Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE Joseph A. Fogarty (Degree or title)			22b. ADDRESS NO 2 5811 Truman Rd N. C. 26 Mo		22c. DATE SIGNED 4/25/57
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 4-26-57	23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		23d. LOCATION (City, town, or country) (State) Hickman Mills, Mo.
24. FUNERAL DIRECTOR Mellody-McGilley-Eylar Funeral Home			25. DATE RECD. BY LOCAL REG. 4-26-57		26. REGISTRAR'S SIGNATURE Reva Marshall

Joseph A. Fogarty USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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.



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 *James W. Wain*

Licensed Embalmer No. *4650*
P. O. Address *K.C., 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.