

FILED MAY 20 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

17420

STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 1992

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 Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN Kansas City Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 4024 Blue Ridge		d. STREET ADDRESS (If outside, give location) 4024 Blue Ridge	
Length of stay in 1b 76 yrs		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last ELIZABETH MARY WENZEL			4. DATE OF DEATH Month Day Year 4 26 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 Oct. 17 1880
9. AGE (In years last birthday) 76 yrs		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. 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) Austria
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13a. FATHER'S NAME Leapold Leitner	
13b. MOTHER'S MAIDEN NAME Mary Schloegle		14. NAME OF HUSBAND OR WIFE Mr. John J. Wenzel	
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. None	17. INFORMANT Address Mrs. Joesph Wenzel, 3636 Indiana
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Pulmonary edema DUE TO (b) Acute Left Ventricular failure DUE TO (c) Arteriosclerotic Cardiovascular			INTERVAL BETWEEN ONSET AND DEATH 12 hrs. 12 hrs. 10 yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Arteriosclerosis & Diabetes Mellitus 3-4 days.			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) 260X	
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 4 to April 26, 1957 and last saw her alive on April 25, 1957 Death occurred at 6:20 am April 26, 1957 on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Robert K. Russell M.D.		22b. ADDRESS Missouri Springs 6187	
22c. DATE SIGNED 4-26-57		23. NAME OF CEMETERY OR CREMATORY Mt Sweet Cem	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 4-29-57	
23c. LOCATION (City, town, or country) Hickman Mo		23d. LOCATION (City, town, or country) Hickman Mo	
24. FUNERAL DIRECTOR Mellody-McGilley-Eylar Funeral Home		25. DATE RECD. BY LOCAL REG. 4-26-57	
26. REGISTRAR'S SIGNATURE Neva Marshall		26. REGISTRAR'S SIGNATURE	

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.

Robert K. Russell

1800 E. Linwood

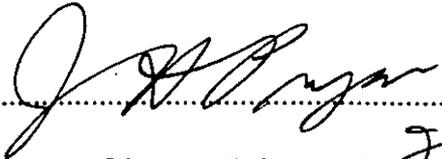
(Licensed Embalmer's Statement on Reverse Side)

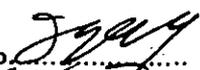


STATEMENT BY LICENSED EMBALMER

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 

Licensed Embalmer No. 

P. O. Address 

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.