

Health,
Welfare
Public
Service

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THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED SEP 16 1957

STATE FILE NUMBER

32252

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 3894

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, give TOWNSHIP only) OR TOWN <u>Kansas City</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Kansas City</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>General Hospital No. 1</u>		Length of stay in lb <u>20 yrs.</u>	d. STREET ADDRESS (If outside, give location) <u>4344 Kensington</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Ewald</u> Middle <u>H.</u> Last <u>Wenninghoff</u>			4. DATE OF DEATH Month <u>8</u> - Day <u>17</u> - Year <u>1957</u>
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-16-02</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Painting</u>	11. BIRTHPLACE (City and state or country) <u>Omaha, Nebraska</u>
13a. FATHER'S NAME <u>Ewald WENNINGHOFF</u>		13b. MOTHER'S MAIDEN NAME <u>Agresta Mertins</u>	14. NAME OF HUSBAND OR WIFE <u>Thecla</u>
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>486-03-2376</u>	17. INFORMANT Address <u>Thecla Wenninghoff - Kansas City Mo.</u>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Post operative hemorrhage</u>			INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause lost. DUE TO (b) <u>Bleeding of branch of sup. mesentery following small bowel resection</u>			5400
DUE TO (c) <u>sub total gastroectomy 12- 1956, gastric ulcer</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I.(a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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 <u>7-29-57</u> to <u>8-17-57</u> and last saw ^{her} him alive on <u>8-17-57</u> Death occurred at <u>7:14 AM</u> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>B. I. Burns, M.D.</u> (Degree or title)		22b. ADDRESS <u>General Hospital No. 1</u>	22c. DATE SIGNED <u>8-19-57</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>8/19/57</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Calvary Cemetery</u>	23d. LOCATION (City, town, or country) (State) <u>K.C. Mo.</u>
24. FUNERAL DIRECTOR <u>Hellody-McGilley-Eylar</u> ADDRESS <u>1800 E. Linwood</u>		25. DATE RECD. BY LOCAL REG. <u>8-19-57</u>	26. REGISTRAR'S SIGNATURE <u>neve Marshall</u>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

B. I. Burns



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 E. Hackler*

Licensed Embalmer No. *45-173*
P. O. Address *H. C. Moore*

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.