

FILED NOV 5 1957

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

35821

STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4773

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 checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Kansas City</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Joseph Hospital</u>			Length of stay in lb <u>11 days 50 yrs.</u>		d. STREET ADDRESS (If outside, give location) <u>913 West 26th St.</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>Joseph Geier</u>				4. DATE OF DEATH Month Day Year <u>October 14, 1957</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</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>January 19, 1885</u>		9. AGE (In years last birthday) <u>72</u>	10. FUNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Packing House Worker</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Meat Industry</u>	11. BIRTHPLACE (City and state or country) <u>Bavaria, Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Unkown</u>			13b. MOTHER'S MAIDEN NAME <u>Unkown</u>		14. NAME OF HUSBAND OR WIFE <u>Mrs. Louise Geier</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>510-05-8859</u>	17. INFORMANT Address <u>Mrs. Joseph Geier 913 W. 26th K.C., 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>Acute Pulmonary Embolism</u>						INTERVAL BETWEEN ONSET AND DEATH <u>10 Min</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Adenocarcinoma of Prostate</u>						<u>1 MO</u>	
DUE TO (c) _____						<u>154+</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 type="checkbox"/> NO <input checked="" type="checkbox"/> <u>2-</u>	
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>Oct 3 1957</u> to <u>Oct 14-57</u> and last saw <del>him</del> <sup>her</sup> alive on <u>Oct 14-57</u> Death occurred at <u>6:30 PM</u> m on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <u>John T. Skinner MD</u> (Degree or title)*				22b. ADDRESS <u>1102 Grand St. R. C. Mo</u>		22c. DATE SIGNED <u>10-15-57</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>10-17-57</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. Marys Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Kansas City, Missouri</u>		
24. FUNERAL DIRECTOR ADDRESS <u>QUIRK &amp; TOBIN 20 West Linwood</u> <u>FUNERAL HOME K. C., Mo.</u>			25. DATE RECD. BY LOCAL REG. <u>10-16-57</u>	26. REGISTRAR'S SIGNATURE <u>Neva Marshall</u>			

All diseases in Part I must be causally related.  
 Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed.  
 John T. Skinner

 USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
 MEDICAL CERTIFICATION



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 *E. C. Gibson* .....

Licensed Embalmer No. *4137* .....

P. O. Address *75 E 7th* .....

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.