

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

47274
STATE FILE NUMBER
6126

FILED JAN 17 1958

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

V. S. 300
Rev. 1-57

1. PLACE OF DEATH a. COUNTY JACKSON		2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE MISSOURI b. COUNTY JACKSON	
b. CITY (If outside corporate limits, give TOWNSHIP only) KANSAS CITY		Inside Limits Yes <input checked="" type="checkbox"/> No <input 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) V A HOSPITAL		Length of stay in 1b 11 years	d. STREET ADDRESS (If outside, give location) 115 WEST 39 TH Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First ROBERT Middle FRED Last HAHLEN			4. DATE OF DEATH Month December Day 23 Year 1957
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 1, 1892
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cabinet Refinisher		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Wadam, Illinois
13a. FATHER'S NAME Carl Hahlen		13b. MOTHER'S MAIDEN NAME Elisa Scigenthaler	14. NAME OF HUSBAND OR WIFE
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WWI		16. SOCIAL SECURITY NO. 333 01 5581	17. INFORMANT Address VA Hospital Official Records, K. C. 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) Purulent diffise peritonitis Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) Perforated fundal gastric ulcer			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Carcinoma, cardia of stomach, metastatic to right upper lung lobe 15/18			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 _____ a.m. _____ p.m. Month, Day, Year _____		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. Attended the deceased from December 23, 1957 to December 23, 1957 Death occurred at 11:45 A in on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <i>Geo. C. Kealhofer</i>		22b. ADDRESS 6627 Piedmont St. Dubuque	22c. DATE SIGNED 12-24-57
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL	23b. DATE DEC 24 1957	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or county) (State) DUBUQUE IOWA
24. FUNERAL DIRECTOR DW. NEW COMER'S SONS		ADDRESS 1331 BRUSH CREEK KANSAS CITY MO	25. DATE RECD. BY LOCAL REG. 12-25-57
26. REGISTRAR'S SIGNATURE <i>Neva Trunshell</i>			

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.

MEDICAL CERTIFICATION
 USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Geo. C. Kealhofer



STATE OF TEXAS
DEPARTMENT OF HEALTH
DIVISION OF PUBLIC HEALTH

HEALTH
DEPARTMENT
DIVISION OF PUBLIC HEALTH
STATE OF TEXAS

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HEALTH

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 Chester K. Braun

HEALTH DEPARTMENT
DIVISION OF PUBLIC HEALTH
STATE OF TEXAS
Licensed Embalmer No. 493

P. O. Address KE YHO

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.