

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-009755
STATE FILE NUMBER
1077

FILED MAR 19 1959

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

300
-57

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo b. COUNTY Jackson	
b. CITY (If outside corporate limits, give TOWNSHIP only) KANSAS CITY		c. CITY OR TOWN KANSAS CITY	
c. FULL NAME OF (If not in hospital, give location) HOSPITAL OR INSTITUTION Lake Side HOSPITAL		d. STREET ADDRESS (If outside, give location) 4503 PARK AVE.	
3. NAME OF DECEASED (Type or print) First Middle Last Joseph Andrew Wimmers		4. DATE OF DEATH Month Day Year 2 23 59	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-24-94
9. AGE (In years last birthday) 64		10. CITIZENSHIP (City and state or country) K.C. MO	
11. OCCUPATION RETIRED OPERATOR & SALES MAN		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME Andrew Wimmers		13b. MOTHER'S MARDEN NAME EMMA KUNZELY	
14. NAME OF HUSBAND OR WIFE Christine WIMMERS		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) World War I	
16. SOCIAL SECURITY NO. 487-34-5504		17. INFORMANT Robert Wimmers - Wilmington, Ohio	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremic Poisoning & Acidosis DUE TO (b) Diabetes DUE TO (c) Shock from Fractured Hip Complicated			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) F			
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. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
20e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from 2-16-59 to 2-23-59 and last saw him alive on 2-23-59 Death occurred at 11:55 A.M. on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) J. D. Schwab		22b. ADDRESS Kansas Mo	
22c. DATE SIGNED 2/23/59		22d. LOCATION (City, town, or county) (State)	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE FEB. 26, 1959	
23c. NAME OF CEMETERY OR REPOSITORY MT. WASHINGTON CEMETERY		23d. LOCATION (City, town, or county) (State) KANSAS CITY MISSOURI	
24. FUNERAL DIRECTOR D. W. NEWCOMER'S SONS KANSAS CITY, MO.		25. DATE RECD. BY LOCAL REG. 2-26-59	
26. REGISTRAR'S SIGNATURE Irene Marshall			

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

J. D. Schwab

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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 *Harold E. Carter*

Licensed Embalmer No. *3035* P. O. Address *at ...*

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.