

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-013143

8
FILED MAY 1 1959

Registration District No. 149 Primary Registration District No. 1022 STATE FILE NUMBER 1895 Registrar's No.

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Kansas b. COUNTY Linn	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN LaCygne 8580
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Trinity Lutheran		Length of stay in 1b 36 hrs	d. STREET ADDRESS None (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last Charles Walter AELMORE			4. DATE OF DEATH Month Day Year - 4 14 59
5. SEX Ma	6. COLOR OR RACE Wh	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-16-1888
9. AGE (In years last birthday) 71		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) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Carpentry	11. BIRTHPLACE (City and state or country) Galva, Kansas
12. CITIZEN OF WHAT COUNTRY? USA		13a. FATHER'S NAME August Aelmore	
13b. MOTHER'S MAIDEN NAME Martha Catlin		14. NAME OF HUSBAND OR WIFE Mrs. Inez Aelmore	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW I		16. SOCIAL SECURITY NO. 509-09-3836	17. INFORMANT Address Mrs. Inez Aelmore, LaCygne, Kansas
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 Cardiac Distention			INTERVAL BETWEEN ONSET AND DEATH 5 min
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Pulmonary Embolism			5 min
DUE TO (c) Following Acute Intestinal Obstruction			48 hrs.
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"/>
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 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 Manda Apr 13-59 to June 14-59 and last saw him alive on June 14th-59 Death occurred at 8:10 p.m. on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Carl R. Knox M.D.		22b. ADDRESS 1220 Rialto Bldg	22c. DATE SIGNED 4-16-59
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 4-14-59	23c. NAME OF CEMETERY OR CREMATORY McPherson Cemetery	23d. LOCATION (City, town, or county) (State) McPherson, Kansas
24. FUNERAL DIRECTOR ADDRESS Wagner Funeral Home, K6 Mo		25. DATE RECD. BY LOCAL REG. 4-16-59	26. REGISTRAR'S SIGNATURE Neva Marshall

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

Earl R. Knox

This certificate is valid only if accompanied by certificate in item 10. No symptoms will be stated.



6201 4 7007

D. E. H. Hand
gr 2-1282

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 *Alvin R. Haunschild*

Licensed Embalmer No. *4157*
P. O. Address *H. E. M.*

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.

