

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-013259

STATE FILE NUMBER

FILED APR 20 1959

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 1717

300  
1-57

1. PLACE OF DEATH a. COUNTY: <b>Jackson</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Jackson</b>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kansas City</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Kansas City</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Trinity Hosp.</b>		Length of stay in lb <b>33 yrs.</b>	d. STREET ADDRESS (If outside, give location) <b>1208 Denver</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>P.</b> Last <b>Donner Sr.</b>			4. DATE OF DEATH Month <b>April</b> Day <b>3</b> Year <b>1959</b>		
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 24, 1899</b>	9. AGE (In years last birthday) <b>59</b>	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) <b>Machine Operator</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Manley Inc.</b>	11. BIRTHPLACE (City and state or country) <b>Berlin, Germany</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>
13a. FATHER'S NAME <b>Unknown</b>		13b. MOTHER'S MAIDEN NAME <b>Unknown</b>		14. NAME OF HUSBAND OR WIFE <b>Lucie L. Donner</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>495-05-0758</b>		17. INFORMANT Address <b>Lucie L. Donner 1208 Denver</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Subarachnoid hemorrhage</b>					INTERVAL BETWEEN ONSET AND DEATH <b>10 hrs</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Rupture of Arterio-Sclerotic aneurysm</b>					<b>10 hrs</b>
DUE TO (c)					
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.) <b>33CX</b>		
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 <b>April 3, 1959</b> , to <b>April 3, 1959</b> and last saw <sup>him</sup> alive on <b>April 3, 1959</b> Death occurred at <b>7:40pm</b> on the date stated above; and to the best of my knowledge, from the causes stated.					
22p. SIGNATURE (Degree or title) <b>Edw. H. Fischer M.D.</b>			22b. ADDRESS <b>306 E. 2<sup>nd</sup> NKC 16 MO</b>		22c. DATE SIGNED <b>4/4/59</b>
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)
<b>burial</b>		<b>Apr. 6, 1959</b>	<b>Elmwood Cemetery</b>		<b>Kansas City, Missouri</b>
24. FUNERAL DIRECTOR ADDRESS <b>Earp &amp; Sons 4707 Truman Rd.</b>			25. DATE RECD. BY LOCAL REG. <b>4-4-59</b>		26. REGISTRAR'S SIGNATURE <b>Reva Marshall</b>

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

Edw. H. Fischer

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 *John B. Corp* .....

Licensed Embalmer No. *2955*  
P. O. Address *P. O. No.*

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.