

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-017704

STATE FILE NUMBER

2172

FILED MAY 29 1959

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

300
1-57

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Kansas</u> b. COUNTY <u>Marshall</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>Marysville</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Research Hosp.</u>		Length of stay in 1b <u>15 days</u>	d. STREET ADDRESS (If outside, give location) <u>8150 (N.H.N.) North St.</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Frank</u> Middle <u>(N.M.N.)</u> Last <u>Folz</u>			4. DATE OF DEATH Month <u>Apr.</u> Day <u>29</u> Year <u>1959</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/12/87</u>	9. AGE (In years last birthday) <u>71 yrs.</u> 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) <u>ret. farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>self-emp.</u>	11. BIRTHPLACE (City and state or country) <u>Carthage, Illinois</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13a. FATHER'S NAME <u>John Folz</u>		13b. MOTHER'S MAIDEN NAME <u>Edna E. Collins</u>		14. NAME OF HUSBAND OR WIFE <u>Ethel Folz</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>none</u>	17. INFORMANT <u>Hosp. Records Research Hosp.</u> Address _____		
18. CAUSE OF DEATH (Enter only one cause for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia & lung abscess</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Atelectasis</u> DUE TO (c) <u>Post operative retained secretion</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Left Radical Neck dissection done 4/16/59 for recurrent Cancer Thyroid</u>					INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>4 days</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 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>4/14/59</u> to <u>4/29/59</u> and last saw her alive on <u>4/28/59</u> Death occurred at <u>about 6:30 p.m.</u> on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>William A. Leo</u> (Name or title)		22b. ADDRESS <u>1612 Professional Bldg., K.C.Mo.</u>		22c. DATE SIGNED <u>4/30/59</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE <u>5/1/59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Marysville City Cem.</u>		23d. LOCATION (City, town, or county) <u>Marysville, Kansas</u>
24. FUNERAL DIRECTOR <u>Geo. F. Porter & Sons</u>		ADDRESS <u>K.C.Ks.</u>		25. DATE RECD. BY LOCAL REG. <u>5-1-59</u>	26. REGISTRAR'S SIGNATURE <u>Neva Marshall</u>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

William A. Leo

All diseases in Part I must be causally related.



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 Howard L. Porter

Licensed Embalmer No...3751.....

P. O. Address...19th & Minnesota Kansas City, Ks

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.