

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-018035

FILED JUN 9 1959

Registration District No. 149 Primary Registration District No. 1002

STATE FILE NUMBER 2467
Registrar's No.

300
-57 4

1. PLACE OF DEATH a. COUNTY JACKSON		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before a. STATE MISSOURI 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) ELMS NURSING HOME		d. STREET ADDRESS 4526 FOREST	

3. NAME OF DECEASED (Type or print) First Middle Last MAX F WINKLER			4. DATE OF DEATH Month Day Year MAY 14, 1959		
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5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH NOV. 19, 1884	9. AGE (In years last birthday) 74	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MUSICIAN	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) ST. JOSEPH, MISSOURI	12. CITIZEN OF WHAT COUNTRY? U. S. A.
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13a. FATHER'S NAME ALOIS WINKLER	13b. MOTHER'S MAIDEN NAME PAULINE HALBIG	14. NAME OF HUSBAND OR WIFE ARDELLA WINKLER
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. 487-16-4290	17. INFORMANT Mrs. Ardella Winkler 4526 Forest Avenue
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) A-S Heart disease		INTERVAL BETWEEN ONSET AND DEATH 177
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) 4260H		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Adenocarcinoma of Prostate with Multiple Metastases		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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.)
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20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.	20d. INJURY OCCURRED WHILE AT WORK <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
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21. I attended the deceased from 8-14-54 to 5-14-59 and last saw him alive on 5-13-59 Death occurred at 6:30 P. m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Wm. A. Stagg M.D.	22b. ADDRESS 1030 Apple KC Mo	22c. DATE SIGNED 5-15-59
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23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	23b. DATE May 19, 1959	23c. NAME OF CEMETERY OR CREMATORY D.W. Newcomers Sons	23d. LOCATION (City, town, or county) (State) Kansas City, Missouri
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24. FUNERAL DIRECTOR D. W. NEWCOMER'S SONS-KANSAS CITY, MO.	25. DATE RECD. BY LOCAL REG. 5-18-59	26. REGISTRAR'S SIGNATURE Mevan Marshall
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MEDICAL CERTIFICATION USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE Wm. A. Stagg

All causes of death 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 *Vern Lawler*

Licensed Embalmer No. *4915*
P. O. Address *KC Mo*

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.