

FURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-036057

FILED VS NOV 2 1959

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4954

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>JACKSON</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>JACKSON</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>KANSAS City</u>		Length of stay in 1b <u>60 YRS</u>	c. CITY OR TOWN <u>KANSAS City</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Marys Hospital</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>4340 Jarboe</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>HELENE</u> Middle <u>M.</u> Last <u>ARNOLD</u>	4. DATE OF DEATH Month <u>OCT</u> Day <u>12</u> Year <u>1959</u>
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5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>8-15-1898</u>	9. AGE (last birthday) <u>61</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Finance office of Assessor</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>City Hall Kansas City Mo.</u>	11. BIRTHPLACE (City and state or country) <u>KANSAS City Kan</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.</u>
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13a. FATHER'S NAME <u>HENRY A STEVENIN</u>	13b. MOTHER'S MAIDEN NAME <u>Myrtle Roach</u>	14. NAME OF HUSBAND OR WIFE <u>Herman W. Arnold</u>
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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) <u>NO</u>	16. SOCIAL SECURITY NO. <u>NONE</u>	17. INFORMANT <u>H.W. Arnold</u>	Address <u>4340 Jarboe K.C. Mo</u>
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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) <u>Acute Myeloid Leukemia</u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 Days</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (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)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

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.)
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____

20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" 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 8-20-59 to 10-12-59 and last saw ^{her}him alive on 10-12-59
Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>Geo C Koehler M.D.</u>	22b. ADDRESS <u>662 7th Street S.O.W.</u>	22c. DATE SIGNED <u>10-16-59</u>
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23a. BURIAL, CREMATION, OR OTHER DISPOSITION (Specify) <u>BURIAL</u>	23b. DATE <u>Oct 15-1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Forest Hill Cem</u>	23d. LOCATION (City, town, or county) (State) <u>KANSAS City Missouri</u>
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24. FUNERAL DIRECTOR <u>Geo C Koehler</u> ADDRESS <u>1901 Olive Bldg</u>	25. DATE RECD. BY LOCAL REG. <u>10-15-59</u>	26. REGISTRAR'S SIGNATURE <u>Shirley Marshall</u>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF Geo C Koehler

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 Paul R. Williamson

Licensed Embalmer No. 5009

P. O. Address Overland Park
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.