

MURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS DEC 30 1959

'59 Q 44075
6018 STATE FILE NUMBER

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

MEMENDED

1. PLACE OF DEATH a. COUNTY Jackson				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Jackson											
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City		Length of stay in lb 5 yrs.		c. CITY OR TOWN Kansas City		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>									
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Lukes			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 428 E. 72nd St.		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>								
3. NAME OF DECEASED (Type or print) First Emma Middle Anschutz Last Anschutz				4. DATE OF DEATH Month Dec. Day 14 Year 1959											
5. SEX Female		6. COLOR OR RACE White		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH Oct. 31, 1872		9. AGE (last birthday) 87		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HR			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) Glasgow, Mo.		12. CITIZEN OF WHAT COUNTRY U.S.A.							
13a. FATHER'S NAME Phillip Wahl				13b. MOTHER'S MAIDEN NAME Mary Baier				14. NAME OF HUSBAND OR WIFE August Anschutz							
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. None		17. INFORMANT Leon Wahl, Kansas City, Missouri				Address							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure										INTERVAL BETWEEN ONSET AND DEATH 36 hours					
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Arteriosclerotic heart disease										25 yrs					
DUE TO (c)															
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Fracture left hip (b) Diabetes (c) Paralytic stroke										PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT <input checked="" 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.) Fall in home 12-9-59 - fractured left hip											
20c. TIME OF INJURY 8:30 p.m. Dec 9 '59		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.) Home		20f. CITY, TOWN, OR LOCATION Kansas City		COUNTY Jackson		STATE Mo	
21. I attended the deceased from 12-9-59 to 12-14-59 and last saw her/him alive on 12-14-59 Death occurred at around 12 AM 12-14-59 on the date stated above, and to the best of my knowledge, from the causes stated.															
22a. SIGNATURE Paul W Mayer M.D.						22b. ADDRESS 4312 J.C. Nichols Plaza				22c. DATE SIGNED 12-14-59					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 12-15-59		23c. NAME OF CEMETERY OR CREMATORY Mt. Moriah				23d. LOCATION (City, town, or county) Kansas City, Missouri				(State)			
24. FUNERAL DIRECTOR Kansas City, Missouri						ADDRESS Stine & Melchre				25. DATE RECD. BY LOCAL REG. 12-15-59		26. REGISTRAR'S SIGNATURE Norm Minshall			

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

Paul W Mayer

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by

or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed William M. Furnal

Licensed Embalmer No. 464

P.O. Address Kansas City, 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.