

**DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

-60-001932

FILED VS FEB 4 1960

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Registration-District No. 149 Primary Registration District No. 1002 Registrar's No. 437

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) <u>Kansas City Mo</u>		Length of stay in 1b <u>40 yrs</u>		c. CITY OR TOWN <u>Kansas City Mo</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>Lakeside Hospital</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>15 W 79th Ter</u>			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>Mrs Pauline Jennie Lutter</u>				4. DATE OF DEATH Month Day Year <u>1-23-1960</u>			
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>6-28-1886</u>	9. AGE (last birthday) <u>74</u>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>at Home</u>		11. BIRTHPLACE (City and state or country) <u>Scranton Kansas</u>		12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>
13a. FATHER'S NAME <u>Emil Mickelson</u>			13b. MOTHER'S MAIDEN NAME <u>Camelia</u>		14. NAME OF HUSBAND OR WIFE <u>Harland G Lutter</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>Harland G Lutter 15 W 79th Ter KCMO</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:							INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)						<u>Toxemia</u>	<u>5 days</u>
DUE TO (b)						<u>Glomerulonephritis</u>	<u>3 mo.</u>
DUE TO (c)						<u>Uremic Pericarditis</u>	<u>6 mo.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (e)						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 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 a.m. p.m. Month, Day, Year							
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	
				<u>Kansas City, Jackson Mo</u>			
21. I attended the deceased from <u>Aug 1959</u> to <u>Jan 23 1960</u> last saw her alive on <u>Jan 23 1960</u> Death occurred at <u>8:10 pm</u> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>G. W. Mount, D.O.</u>				22b. ADDRESS <u>512 West 79th St Kans. City Mo</u>		22c. DATE SIGNED <u>1-25-60</u>	
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>1-26-60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt Moriah</u>		23d. LOCATION (City, town, or county) (State) <u>Kansas City Mo</u>		
24. FUNERAL DIRECTOR <u>France Wornall Funeral Home KCMO</u>			ADDRESS <u>1-25-60</u>		25. DATE RECD. BY LOCAL REG. 26. REGISTRAR'S SIGNATURE <u>Neal Marshall</u>		

DOCUMENT

G. W. MOUNT MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**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 Russell N. Fra

Licensed Embalmer No. 425

P. O. Address K.C. 7

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.