

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-026701

FILED VS AUG 8 1960

149

Registration District No. *1002*

Registrar's No. **3844**

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY Jackson			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Kansas b. COUNTY Johnson			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City		Length of stay in 1b 4 days	c. CITY OR TOWN Prairie Village		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Trinity Lutheran		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 5517 West 70th. Terr		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First WILLIAM Middle (none) Last ANSCHUTZ			4. DATE OF DEATH Month July Day 23 Year 1960			
5. SEX Male	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 10-23-79	9. AGE (last birthday) 80	IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Collector		10b. KIND OF BUSINESS OR INDUSTRY Union Credit Co	11. BIRTHPLACE (City and state or country) Missouri		12. CITIZEN OF WHAT COUNTRY USA	
13a. FATHER'S NAME August Anschutz		13b. MOTHER'S MAIDEN NAME Carolyn Kuemmel		14. NAME OF HUSBAND OR WIFE Rose Anschutz (dec.)		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war and dates of service) No None		16. SOCIAL SECURITY NO. 486-01-3852	17. INFORMANT Address Margaret Anschutz <i>Prairie Village, Mo.</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE WITH ATRIAL FIBRILLATION AND DECOMPENSATION					INTERVAL BETWEEN ONSET AND DEATH 1 YEAR	
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) TOXEMIA FROM PNEUMONITIS & ENTERITIS				PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> N. <input type="checkbox"/> Unknown		
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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	
21. I attended the deceased from <u>July 19, 1960</u> to <u>July 23, 1960</u> and last saw him alive on <u>July 23, 1960</u> Death occurred at <u>10:30 a</u> m on the date stated above, and to the best of my knowledge, from the causes stated.						
22a. SIGNATURE (Degree or title) <i>James W. Fowler, MD.</i>			22b. ADDRESS 1103 GRAND AVE KANSAS CITY, MO.		22c. DATE SIGNED 7-25-60	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 7-26-60	23c. NAME OF CEMETERY OR CREMATORY Forest Hill		23d. LOCATION (City, town, or county) (State) Kansas City, Missouri		
24. FUNERAL DIRECTOR (Name and address) John & McClure Funeral Home Kansas City, Missouri.			25. DATE RECD. BY LOCAL REG. 7-26-60	26. REGISTRAR'S SIGNATURE <i>Anna Marshall</i>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF James W. Fowler

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. Jura

Licensed Embalmer No. 464

P. O. Address Sparks City

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.