

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

268461-017398

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

2684

STATE FILE NUMBER

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

AMENDED

FILED JUN 12 1961

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 1b 60 years	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 6740 Bales Avenue		d. STREET ADDRESS (If outside, give location) 6740 Bales Avenue	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First WILLIEL Middle LORENZ Last DILLENSCHNEIDER			4. DATE OF DEATH Month May Day 28 Year 1961			
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 10/30/93	9. AGE (last birthday) 67	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cabinet Maker	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Rock Island, Illinois	12. CITIZEN OF WHAT COUNTRY U.S.A.
13a. FATHER'S NAME Lorenz Dillenschneider	13b. MOTHER'S MAIDEN NAME Marie Valentine	14. NAME OF HUSBAND OR WIFE Ella May Dillenschneider	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	17. INFORMANT Ella May Dillenschneider	Address 6740 Bales K.C.Mo.
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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) CORONARY OCCLUSION		INTERVAL BETWEEN ONSET AND DEATH SUBDUE
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) OLD A.G.C.V. DIS. - DECOMPRESSION	
	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
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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 _____

21. I attended the deceased from **2-4-49** to **5-28-61** and last saw him alive on **2-13-61**
Death occurred at **2-28-61** p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <i>[Signature]</i>	(Degree or title)	22b. ADDRESS 6240 Prospect Kshs	22c. DATE SIGNED 5-29-61
23a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION	23b. DATE MAY 31, 1961	23c. NAME OF CEMETERY OR CREMATORY D. W. NEWCOMER'S SONS	23d. LOCATION (City, town, or county) (State) KANSAS CITY MISSOURI
24. FUNERAL DIRECTOR D.W. Newcomer's Sons, Kansas City, Mo		25. DATE RECD. BY LOCAL REG. 5-31-61	26. REGISTRAR'S SIGNATURE <i>[Signature]</i>

(Licensed Embalmer's Statement on Reverse Side)

DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF *Stigard*

ITEM NO. SHOULD READ

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 Genub. Michael

Licensed Embalmer No. 4340

P. O. Address K. C. 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.