

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

425561-029515
STATE FILE NUMBER

AMENDED

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

FILED SEP 8 1961

1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)			
a. COUNTY Jackson		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City		a. STATE Missouri		b. COUNTY Jackson	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 4041 Walnut		Length of stay in 1b 11 Years		c. CITY OR TOWN Kansas City		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. STREET ADDRESS 4041 Walnut		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 4041 Walnut		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)			4. DATE OF DEATH			Month Day Year	
HERMAN SALM MUENTEFERING			August 26 1961				
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 3-18-1874	9. AGE (last birthday) 87	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) Retired Motel Operator		10b. KIND OF BUSINESS OR INDUSTRY Motel		11. BIRTHPLACE (City and state or country) Florence, Kansas		12. CITIZEN OF WHAT COUNTRY USA	
13a. FATHER'S NAME Herman S. Muentefering Sr.			13b. MOTHER'S MAIDEN NAME Elizabeth Mori			14. NAME OF HUSBAND OR WIFE Gertrude Muentefering	
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. ---		17. INFORMANT Address Gertrude Muentefering 4041 Walnut		
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) Cerebral vascular accident & myocardial failure						2 months	
DUE TO (b) General arteriosclerosis &						10 yrs.	
DUE TO (c) arteriolosclerotic heart disease							
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 if 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 Sept. 5, 1959 to Aug. 26, 1961 and last saw ^{her} him alive on Aug. 26, 1961 Death occurred at approx. 8:00 P. on the date stated above, and to the best of my knowledge, from the causes stated.							
22. SIGNATURE (Degree or title) <i>Edward C. Teubel M.D.</i>				22b. ADDRESS 4304 Troost, K.C., Mo.		22c. DATE SIGNED Aug. 27, 61	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE August 27 1961		23c. NAME OF CEMETERY OR CREMATORY Forest Lawn Cemetery		23d. LOCATION (City, town, or county) (State) Omaha, Neb.	
24. FUNERAL DIRECTOR ADDRESS Melody McGilley Elyar 1800 E. Linwood				25. DATE RECD. BY LOCAL REG. 8-27-61		26. REGISTRAR'S SIGNATURE <i>Ruth Long</i>	

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

INSTEAD OF

SHOULD READ

DOCUMENT

BY AFFIDAVIT OF EDWARD C. TEUBEL MEDICAL CERTIFICATION

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 Lloyd F. Dickerson

Licensed Embalmer No. 5120

P. O. Address K.C. 9, 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.