

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

0050904  
STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

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

**FILED JAN 17 1964**

VS 300	AMENDED	DATE AMENDED
Rev. 4/59		
1		
2 <u>7005</u>		
3		
4 <u>1</u>		
5 <u>2</u>		
6		
7 <u>1</u>		
8 <u>0</u>		
<u>332XH</u>		
10		
11		
<u>1268-0</u>		
13		
AMENDMENTS ON THIS RECORD ARE AS FOLLOWS		DOCUMENT
INSTEAD OF		
SHOULD READ		
ITEM NO.		
BY AFFIDAVIT OF		
MEDICAL CERTIFICATION		
E. G. Kettner		

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) OR TOWN <u>Kansas City</u>		Length of stay in 1b <u>27 days</u>	c. CITY OR TOWN <u>Independence</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>Trinity Lutheran Hosp.</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>1514 E. Truman Rd.</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>ANNA KIRCHNER STEINBERG</u>		4. DATE OF DEATH Month Day Year <u>December 30, 1963</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>3-1875</u>
9. AGE (last birthday) <u>87</u>		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) <u>Owner &amp; Operator</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Rooming Houses</u>	11. BIRTHPLACE (City and state or country) <u>Sedan, Kansas</u>
12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>		13a. FATHER'S NAME <u>Jacob Kirchner</u>	
13b. MOTHER'S MAIDEN NAME <u>Gertrude Steinweden</u>		14. NAME OF HUSBAND OR WIFE <u>Arthur Steinberg</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 Address <u>Ben J. Kirchner, 1514 E. Truman Rd.</u>
18. CAUSE OF DEATH (Enter only one cause per death) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cerebral thrombosis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 mo.</u>
Conditions, if any, which gave rise to above cause (b), 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) <u>Cancer in 7 brain</u>			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 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>1952</u> to <u>Dec 30, 1963</u> and last saw her alive on <u>Dec 30, 1963</u> Death occurred at <u>11 a.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>E. G. Kettner</u> (Degree or title)		22b. ADDRESS <u>Kansas City, Mo</u>	22c. DATE SIGNED <u>1/2/64</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>1-2-1964</u>	23c. NAME OF CEMETERY*OR CREMATORY <u>Calvary Cemetery</u>	23d. LOCATION (City, town, or county) <u>Kansas City, Missouri</u>
24. FUNERAL DIRECTOR <u>Melody-McGilley-Eylar Funeral Home</u> ADDRESS <u>1800 E. Linwood, Kansas City, Mo</u>		25. DATE RECD. BY LOCAL REG. <u>1-2-64</u>	26. REGISTRAR'S SIGNATURE <u>Bessie Smith</u>

USE BLACK INK OR TYPEWRITER RIBBON

(Licensed Embalmer's Statement on Reverse Side)

Dr. Ed. B. Kettner  
Professional Bldg.  
Before 12 noon Thurs.

copy  
X

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**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 James W. Waver

Licensed Embalmer No. 4650

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.