

250 AUG 7 1939

MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

24642  
Do not use this space.

1. PLACE OF DEATH

(a) County Jackson 3 Registration District No. 395

(b) Township Kaw Primary Registration District No. 1002 Registered No. 2855

(c) City Kansas City, Mo. (d) Street No. Hotel President St.

(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Rev. F. J. Lankenau

(a) Residence, No. \_\_\_\_\_ St.  Napoleon, Ohio  
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Mrs. Helen Lankenau

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) April 6, 1868

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.

71	3	9
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8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Minister

9. Industry or business in which work was done, as saw mill, bank, etc. Lutheran Ch.

10. Date deceased last worked at this occupation (month and year) \_\_\_\_\_ 11. Total time (years) spent in this occupation \_\_\_\_\_

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Bingen, Indiana

FATHER

13. NAME No Record

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Bingen, Indiana

MOTHER

15. MAIDEN NAME Katherine Schumm

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ohio

17. INFORMANT Dr. F. J. Lankenau, Jr.  
(ADDRESS) Winfield, Kansas

18. BURIAL, CREMATION, OR REMOVAL PLACE Waterloo, Ind. DATE July 16, 1939

19. FUNERAL DIRECTOR (NAME) John W. Wagner  
(ADDRESS) Kansas City, Mo.

20. FILED July 16, 1939 M. M. Brome  
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) July 15, 1939

22. I HEREBY CERTIFY That I attended deceased from July 15, 1939, to July 15, 1939

I last saw him alive on July 15, 1939 Death is said to have occurred on the date stated above, at 10:15 PM

The principal cause of death and related causes of importance were as follows:

Acute Myocardial Infarction

Other contributory causes of importance: AIN

Name of operation None Date of \_\_\_\_\_

What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_

23. If death was due to external causes (violence), fill in also the following:  
Accident, suicide, or homicide? No Date of injury \_\_\_\_\_, 19\_\_\_\_  
Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)  
Specify whether injury occurred in industry, in home, or in public place. None

Manner of injury \_\_\_\_\_  
Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased? No  
If so, specify \_\_\_\_\_  
(Signature) W. Paul, M. D.  
(Address) Waterloo, Ind.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

*W. H. Hester*

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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.....  
....., Registered Apprentice No.....  
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

**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 this body is not embalmed, above space should be left blank.**

FILL IN ANSWERS TO ALL SPACES  
CHECKED IN RED PENCIL.

MISSOURI STATE BOARD OF HEALTH  
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CERTIFICATE OF DEATH

24642  
Do not use this space.

1. PLACE OF DEATH

(a) County Jackson Registration District No. 399  
 (b) Township..... Primary Registration District No. 1002  
 (c) City K.C. (d) Street No..... St.  
 (e) Length of residence in city or town where death occurred (If death occurred in Hospital or Institution, write its name instead of street and number)  
 yrs. mos. ds. (f) How long in U.S. if of foreign birth? yrs. mos. ds.

Registered No. 2853-

2. PRINT FULL NAME

(a) Residence, No. Rev Francis James Hankenau St.  (If nonresident, give city or town and State)  
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) M

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 7-18-1939

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

22. I HEREBY CERTIFY, That I attended deceased from

6. DATE OF BIRTH (MONTH, DAY, AND YEAR)

to....., 19.....

7. AGE YEARS MONTHS DAYS If LESS than 1 day, .....hrs. or .....min.  
71 3 9

I last saw h..... alive on....., 19..... Death is said

to have occurred on the date stated above, at.....m.

The principal cause of death and related causes of importance were as follows:

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.  
 9. Industry or business in which work was done, as saw mill, bank, etc.  
 10. Date deceased last worked at this occupation (month and year).....  
 11. Total time (years) spent in this occupation.....

Date of onset

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

Other contributory causes of importance:

FATHER 13. NAME

Name of operation..... Date of.....

What test confirmed diagnosis?..... Was there an autopsy?.....

FATHER 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide?..... Date of injury....., 19.....

Where did injury occur?..... (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

MOTHER 15. MAIDEN NAME

Manner of injury.....

Nature of injury.....

MOTHER 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

24. Was disease of injury in any way related to occupation of deceased?.....

If so, specify.....

(Signed) John W. Paul M. D.

(Address) W. C. 2nd

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE DATE 19

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED 7/16 19 39 M. M. Cronin Local Registrar.

SUPPLEMENTARY

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.  
 CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.  
 PHYSICIANS should state DISEASE.

