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23159

OCT 11 1940

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **31152**
3715
Registrar's No.

Registration District No. _____ Primary Registration District No. _____

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Lakesdie Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 4 Days (Specify whether years, months or days)

In this community 43 Years

3. (a) PRINT FULL NAME Mrs. Katie Hoelzel

3. (b) If veteran, name war None

3. (c) Social Security No. None

4. Sex Female 5. Color or race White

6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Mr. John Frank Hoelzel

6. (c) Age of husband or wife if alive - years

7. Birth date of deceased November 10 1864
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

75 10 12 hr. min.

9. Birthplace Lawrence Kansas
(City, town, or county) (State or foreign country)

10. Usual occupation At Home

11. Industry or business --

12. Name William Altenbernd

13. Birthplace Germany
(City, town, or county) (State or foreign country)

14. Maiden name Kathryn Hill

15. Birthplace Germany
(City, town, or county) (State or foreign country)

16. (a) Informant Jess Hoelzel

(b) Address 1118 276 St. Kemo

17. (a) Burial (b) Date thereof Sept. 24, 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Forest Hill Cemetery

18. (a) Signature of funeral director A. H. Newcomer, Son

(b) Address 1401 Brush Creek Blvd.

19. (a) 9-24-40 (b) M. M. Grove
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson

(c) City or town Kansas City
(If outside city or town limits, write "RURAL")

(d) Street No. 2762 Gillham Road
(If rural, give location)

(e) If foreign born, how long in U. S. A.? -- years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 22nd
year 1940 hour 1 minute 05 P. M.

21. I hereby certify that I attended the deceased from June 21, 1940
to Sept. 22, 1940
that I last saw her alive on Sept. 22, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death uremic poison Duration 6 days

Due to Biliary calculi, chronic Carcinoma of liver with jaundice

Due to Hypertrophic lesion, arthritis, pleuritis with hypertension

Other conditions 126
(Include pregnancy within 9 months of death)

Major findings: Of operations _____

Of autopsy _____

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place)
(e) Means of injury _____

23. Signature Dr. F. G. Demelft M.D. or other DO
Address 2748 Charlotte St. Date signed 9/22/40

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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.....

C. Hervey Quinn

Licensed Embalmer No.....

4078

P. O. Address.....

A. C. M.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.