

Registration District No. 404

Primary Registration District No. 5558

Registrar's No. 89

1. PLACE OF DEATH: Jackson War  
 (a) County \_\_\_\_\_  
 (b) City or town Kansas City, Missouri  
 (c) Name of hospital or institution: Armour Memorial Home  
 (If not in hospital or institution, write street number or location) \_\_\_\_\_  
 (d) Length of stay: In hospital or institution 3 years  
 In this community 5 years

2. USUAL RESIDENCE OF DECEASED:  
 (a) State Missouri (b) County Jackson  
 (c) City or town Kansas City  
 (d) Street No. 81st and Wornall Road  
 (e) If foreign born, how long in U. S. A? No. years.

3. (a) PRINT FULL NAME Mrs. Dell Lloyd Kolkenbeck  
 3. (b) If veteran, name war no.  
 3. (c) Social Security No. no.

MEDICAL CERTIFICATION  
 20. DATE OF DEATH: Month September day 9  
 year 1940 hour 7 minute 15 P.M.

4. Sex Female  
 5. Color or race White  
 6. (a) Single, widowed, married, divorced Widowed  
 6. (b) Name of husband or wife Unknown  
 6. (c) Age of husband or wife if alive X years  
 7. Birth date of deceased December 12 1864

21. I hereby certify that I attended the deceased from Dec 1 - 36, 1936, to Sept 9, 1940  
 that I last saw her alive on Sept 7, 1940  
 and that death occurred on the date and hour stated above.

8. AGE: Years 76 Months 9 Days 9  
 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

Immediate cause of death Neurovascular Stenosis  
 Duration \_\_\_\_\_

9. Birthplace Keithsburg Illinois

Due to \_\_\_\_\_  
 Due to \_\_\_\_\_

10. Usual occupation Stenographer

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

11. Industry or business \_\_\_\_\_  
 12. Name David Lloyd  
 13. Birthplace Pennsylvania  
 14. Maiden name Mary K. Keyser  
 15. Birthplace Pennsylvania

PHYSICIAN  
 Major findings: \_\_\_\_\_  
 Of operations \_\_\_\_\_  
 Of autopsy \_\_\_\_\_  
 Underline the cause to which death should be charged statistically

16. (a) Informant's own signature Armour Home Records  
 (b) Address 81st Wornall Rd

22. If death was due to external causes, fill in the following:  
 (a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
 (b) Date of occurrence \_\_\_\_\_

17. (a) Burial (b) Date thereof 9-11-40  
 (c) Place: burial or cremation Mt. Washington

(c) Where did injury occur? \_\_\_\_\_  
 (d) Did injury occur in or about home, on farm, in industrial place, in public place? 3 1/2  
 (Specify type of place) \_\_\_\_\_  
 While at work? \_\_\_\_\_ (e) Means of injury \_\_\_\_\_

18. (a) Signature of funeral director SHINE-McCLURE  
 (b) Address Kansas City Mo  
 19. (a) 9-15-40 (b) R. V. Lindsey & Sons  
 (Date received local registrar) (Registrar's signature)

28. Signature [Signature] (M. D. or other) \_\_\_\_\_  
 Address 636 Wornall Date signed 9/10/40

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.

118c

12 - 19 - 1958

any other 12-19-58  
2 P.M.

**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

*J B Waters*

Licensed Embalmer No.

*3992*

P. O. Address

*R C Mo*

**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, above space should be left blank.**

10-2B  
1-21-40  
X22659

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

State File No. **32229**  
Registrar's No. **69**

Registration District No. **404**

Primary Registration District No. **55-58**

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

1. PLACE OF DEATH:  
(a) County **Jackson**  
(b) City **Jackson**  
(c) Name of hospital or institution:  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution..... (Specify whether  
In this community..... (Specify whether  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
(a) State..... (b) County.....  
(c) City or town..... (If outside city or town limits write "RURAL")  
(d) Street No..... (If rural, give location)  
(e) If foreign born, how long in U. S. A.?..... years.

3. (a) **Madell Lloyd Kalsenbeck**  
FULL NAME  
3. (b) If veteran, name war.....  
3. (c) Social Security No. ....

20. DATE OF DEATH: month **Sept** day **9**  
year **1940** hour..... minute..... M.

4. Sex **7** 5. Color or race **w** 6. (a) Single, widowed, married, divorced **wid**  
6. (b) Name of husband or wife..... 6. (c) Age of husband, or wife, if alive..... years

21. I hereby certify that I attended the deceased from....., 19....., to....., 19.....; that I last saw h..... alive on....., 19.....; and that death occurred on the date and hour stated above.

7. Birth date of deceased..... (Month) (Day) (Year)  
8. AGE: Years **76** Months **9** Days **9** If less than one day..... hr. min.

Immediate cause of death: **Hemorrhage of stomach**  
Due to: **Rupture of a tubercle 3rd cervical**  
Due to: **N.M.D.**

9. Birthplace..... (City, town, or county) (State or foreign country)  
10. Usual occupation.....  
11. Industry or business.....  
12. Name.....  
13. Birthplace..... (City, town, or county) (State or foreign country)  
14. Maiden name.....  
15. Birthplace..... (City, town, or county) (State or foreign country)

Other conditions..... (Include pregnancy within 3 months of death)  
Major findings: Of operations.....  
Of autopsy.....  
PHYSICIAN **HSC**  
Underline the cause to which death should be charged statistically.

16. (a) Informant.....  
(b) Address.....  
17. (a)..... (b) Date thereof..... (Month) (Day) (Year)  
(c) Place: burial or cremation.....  
18. (a) Signature of funeral director.....  
(b) Address.....  
19. (a)..... (b)..... (Registrar's signature)

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..... (M. D. or other).....  
Address..... Date signed.....

SUPPLEMENTARY

