

FILED APR 16 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 12257

BIRTH NO.		REG. DIST. NO. 149		PRIMARY REG. DIST. NO. 1002		Registrar's No. 1340	
1. PLACE OF DEATH a. COUNTY Jackson				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Kansas b. COUNTY 999			
b. CITY (If outside corporate limits, write RURAL and give township) Kansas City		c. LENGTH OF STAY (In this place) 5 mo.		c. CITY (If outside corporate limits, write RURAL and give township) Wellmore		14	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Joseph Hospital				d. STREET ADDRESS (If rural, give location) 02			
3. NAME OF DECEASED (Type or Print) a. (First) Frederick J. b. (Middle) c. (Last) Achten				4. DATE OF DEATH (Month) (Day) (Year) 3 23 49			
5. SEX M O		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) 7		8. DATE OF BIRTH 6/21/93	
9. AGE (In years last birthday) 55		IF UNDER 1 YEAR Months Days		IF UNDER 6 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Granada, Kans	
12. CITIZEN OF WHAT COUNTRY US							
13a. FATHER'S NAME Frederick P. Achten				13b. MOTHER'S MAIDEN NAME Lillian Donaldson		14. NAME OF HUSBAND OR WIFE Anna	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. —		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Madonna Achten (wife) Wellmore La.	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death. I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Bronchopneumonia ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Spongoblastoma (probable) DUE TO (c) Left Temporal lobe - 1937 II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Cerebral Encephalomalacia				INTERVAL BETWEEN ONSET AND DEATH			
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE <input type="checkbox"/> WORK AT WORK		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.							
23a. SIGNATURE Russell W. Russell				23b. ADDRESS St. Joseph Hospital		23c. DATE SIGNED 23-Mar-49	
24a. BURIAL, CREMATION, REMOVAL (Specify) removed		24b. DATE 3-24-49		24c. NAME OF CEMETERY OR CREMATORY		24d. LOCATION (City, town, or county) (State) Wellmore Kansas	
DATE REC'D BY LOCAL REG. 3-24-49		REGISTRAR'S SIGNATURE Geraldine Holmes		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS R. D. Sutton Wellmore Kansas			

(Licensed Embalmer's Statement on Reverse Side)

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

APR 28 1949

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
Student Embalmer

Signed

M. M. Swisher

Licensed Embalmer No. *3505*

P. O. Address *Mc Kean*

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, fact should be so stated above.