

FILED OCT 7 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

30388

State File No.

BIRTH NO. _____		REG. DIST. NO. <u>149</u>		PRIMARY REG. DIST. NO. <u>1002</u>		Registrar's No. <u>3984</u>	
1. PLACE OF DEATH a. COUNTY <u>Jackson</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before death) a. STATE <u>Kansas</u> b. COUNTY <u>Leavenworth</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Kansas City</u>		c. LENGTH OF STAY (In this place) <u>10 days</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Tonganoxie</u>		X <u>8150</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Trinity Lutheran Hospital</u>				d. STREET ADDRESS (If rural, give location) X <u>8</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Loeh Lea</u> b. (Middle) <u>Dot</u> c. (Last) <u>Emmons</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>Sept. 20, 1950</u>				
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>widow</u> ✓	8. DATE OF BIRTH <u>May 1, 1866</u>		9. AGE (In years last birthday) <u>84</u>	IF UNDER 1 YEAR Months	IF UNDER 6 HRS. Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>		11. BIRTHPLACE (State or foreign country) <u>Illinois</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13a. FATHER'S NAME <u>Robert Kline</u>		13b. MOTHER'S MAIDEN NAME <u>Mary Etta Green Byers</u>		14. NAME OF HUSBAND OR WIFE <u>Fred J. Emmons</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'S SIGNATURE OR NAME ADDRESS <u>Mrs. Tom Butler Tonganoxie, Kans.</u>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)	MEDICAL CERTIFICATION					INTERVAL BETWEEN ONSET AND DEATH	
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>(a) arteriosclerotic gangrene right leg</u>					<u>5 days</u>	
*This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause, (a) stating the underlying cause last. <u>(b) generalized arteriosclerosis</u>					<u>20 yrs. plus</u>	
	DUE TO (c) <u>chronic rheumatoid arthritis</u>					<u>4501</u>	
	II. OTHER SIGNIFICANT CONDITIONS <u>acute hemorrhagic cystitis</u>					<u>15 yrs. plus</u>	
						<u>2 wks.</u>	
19a. DATE OF OPERATION <u>9-12-50</u>		19b. MAJOR FINDINGS OF OPERATION <u>cystoscopy hemorrhagic cystitis</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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 WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>9-12</u> , 19 <u>50</u> , to <u>9-20</u> , 19 <u>50</u> , that I last saw the deceased alive on <u>9-19</u> , 19 <u>50</u> and that death occurred at <u>8:50A</u> m., from the causes and on the date stated above.							
23a. SIGNATURE <u>Joseph E. Welker MD.</u> (Degree or title)				23b. ADDRESS <u>836 Prof. Bldg.</u>		23c. DATE SIGNED <u>9-20-50</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		24b. DATE <u>9-23-50</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Elmwood</u>		24d. LOCATION (City, town, or county) (State) <u>Kansas City, Mo.</u>		
DATE REC'D BY LOCAL REG. <u>9-20-50</u>		REGISTRAR'S SIGNATURE <u>Geraldine Holmes</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Quisenberry Funeral Home Tonganoxie, Ks/</u>			

WRITE PLAINLY—USING 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 _____

working under my personal supervision.

Student Embalmer No.

Signed _____

Signed.....
Student Embalmer

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, fact should be so stated above.

WRITE PLAINLY—USING UNFADING INK

etc. It means: the disease, injury, or complication which caused death.		DUE TO: (c)			
II. OTHER SIGNIFICANT CONDITIONS		Chronic rheumatoid arthritis		15 yrs +	
Conditions contributing to the death but not related to the disease or condition causing death		Nests hemorrhagic cystitis		2 wks	
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION			20. AUTOPSY?	
9/12 *	*Cystoscopy - Hemorrhagic Cystitis.			YES <input type="checkbox"/> NO <input checked="" 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) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?		
22. I hereby certify that I attended the deceased from <u>9/12</u> , 19 <u>50</u> , to <u>9/20</u> , 19 <u>50</u> , that I last saw the deceased alive on <u>9/19</u> , 19 <u>50</u> , and that death occurred at <u>8:50</u> A.M., from the causes and on the date stated above.					
23a. SIGNATURE	Joseph E. Welker MD (Degree or title)	23b. ADDRESS	23c. DATE SIGNED		
<i>Joseph E. Welker MD</i>		836 Prof Bldg. K.C., Mo.	9/20/50		
24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)		
<i>Burial</i>	9/23/50	Elmwood Cem.	Kansas City, Mo.		
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
9-20-50	<i>Heraldine Holmes</i>	<i>Quisenberry Funeral Home</i>		Tanganofie, Mo.	
(Licensed Embalmer's Statement on Reverse Side)					

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.....

.....
working under my personal supervision.

Student Embalmer No.

Student
Student Embalmer

Signed.....

Hervey Quisenberry

Licensed Embalmer No. *4070*

P. O. Address *Tongareva Is.*

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.