

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **26998**
3402

FILED AUG 25 1951

BIRTH MO. _____		REG. DIST. NO. <u>149</u>		PRIMARY REG. DIST. NO. <u>1002</u>		Registrar's No. _____	
1. PLACE OF DEATH a. COUNTY <u>Jackson</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</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>62 years</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Kansas City</u>		d. STREET ADDRESS (If rural, give location) <u>4325 Wyoming</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St. Mary's Hospital</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Aug 6 1951</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>MRS. SOPHIA</u>		b. (Middle) _____		c. (Last) <u>KASTNER</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>Nov 14 1879</u>		9. AGE (In years last birthday) <u>71</u>	
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 _____		11. BIRTHPLACE (State or foreign country) <u>Austrian</u>		12. CITIZEN OF WHAT COUNTRY? _____	
13a. FATHER'S NAME <u>George Loschke</u>		13b. MOTHER'S MAIDEN NAME <u>Sophia Esinsaph</u>		14. NAME OF HUSBAND OR WIFE <u>Karl Kastner</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 <u>Mrs Rose Kelley</u> ADDRESS <u>4325 Wyoming</u>			
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 <u>Carcinoma Gall Bladder</u> ANTECEDENT CAUSES <u>Chronic Cholecystitis</u> Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (a) _____ DUE TO (c) _____				INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u> <u>Hypon</u> <u>155X</u> <u>3 mo</u>	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION <u>Liver metastases</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE <u>No</u>		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) _____	
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>8-31</u> , 19 <u>51</u> , to <u>8-6</u> , 19 <u>51</u> , that I last saw the deceased alive on <u>8-6</u> , 19 <u>51</u> , and that death occurred at _____ m., from the causes and on the date stated above.							
23a. SIGNATURE <u>D. P. Miller MD</u>				23b. ADDRESS <u>St. John's</u>		23c. DATE SIGNED <u>8-8-51</u>	
24a. BURIAL, CREMATION OR REMOVAL <u>Burial</u>		24b. DATE <u>Aug 9 1951</u>		24c. NAME OF CEMETERY OR CREMATORY <u>St. John's</u>		24d. LOCATION (City, town, or county) (State) <u>Kansas City Kans.</u>	
DATE REC'D BY LOCAL REG. <u>8-8-51</u>		REGISTRAR'S SIGNATURE <u>Sheraldine Holmes</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Dwight Robin</u> ADDRESS <u>20 West Linwood</u>			

WRITE PLAINLY—USING UNFAADING 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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed Forest D. Coldman

Licensed Embalmer No. 4214

P. O. Address K. E. Mo.

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.