

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

18307

State File No.

2436

BIRTH NO. _____ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No.

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Jackson	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kansas City		c. CITY OR TOWN Kansas City	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. LENGTH OF STAY (in this place) 3 yrs		e. STREET ADDRESS (If rural, give location) 4544 Olive	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Joseph Hospital			

3. NAME OF DECEASED (Type or Print) William	a. (First)	b. (Middle) U	c. (Last) Uhlhorn	4. DATE OF DEATH (Month) (Day) (Year) 5 8 53
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5. SEX M	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH 8-9-1893	9. AGE (In years last birthday) 59	IF UNDER 1 YEAR Months	IF UNDER 1 YEAR Days	IF UNDER 1 HR. Hours	IF UNDER 1 HR. Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MEAT CUTTER	10b. KIND OF BUSINESS OR INDUSTRY WILLIAMS MEAT CO.	11. BIRTHPLACE (City and State or Foreign Country) GERMANY	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME CARL UHLHORN	13b. MOTHER'S MAIDEN NAME MARIA DUNEKAKEANNA UHLHORN	14. NAME OF HUSBAND OR WIFE ANNA UHLHORN
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. 505-03-7067	17. INFORMANT'S SIGNATURE OR NAME ANNA UHLHORN	ADDRESS 4544 OLIVE K.C. MO.
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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, ashenia, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Sarcoid		INTERVAL BETWEEN ONSET AND DEATH few weeks
	ANTECEDENT CAUSES DUE TO (b) of Kidney (left)		
	DUE TO (c) Primary - undetermined		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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)
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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?
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22. I hereby certify that I attended the deceased from **4-8**, 19**53**, to **5-8**, 19**53**, that I last saw the deceased alive on **5-8**, 19**53**, and that death occurred at **10:30** m., from the causes and on the date stated above.

23a. SIGNATURE B. Atcheson	(Degree or title) M.D. MD	23b. ADDRESS 9830 Prospect	23c. DATE SIGNED
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 5-11-53	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State) St. Joseph Mo.
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DATE REC'D BY LOCAL REG. 5-11-53	REGISTRAR'S SIGNATURE Sheldine Smith	25. FUNERAL DIRECTOR'S SIGNATURE Melody-McGilley-Eylar	ADDRESS KCMO.
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

Dr. Atchison
3850 Prospect
Wa. 6110

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.....
Signature of Student Embalmer

Signed.....
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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.