

FILED APR 6 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 8679

BIRTH NO. _____ REG. DIST. NO. 171 PRIMARY REG. DIST. NO. 4266 Registrar's No. 14

1. PLACE OF DEATH a. COUNTY Lafayette			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Lafayette			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Wellington		c. LENGTH OF STAY (in this place) c. CITY OR TOWN Wellington		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION 2bl. south of 24 highway 1 east						
3. NAME OF DECEASED (Type or Print) a. (First) LAURA b. (Middle) JOHANNA c. (Last) KOHLSTAEDT			4. DATE OF DEATH (Month) (Day) (Year) March 29 1955			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Sept. 24, 1889	9. AGE (In years) (Specify last birthday) 65	IF UNDER 1 YEAR Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (City and State or Foreign Country) Chamois, Missouri		
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13a. FATHER'S NAME Fred Stocksick		13b. MOTHER'S MAIDEN NAME Cristena Willard		
14. NAME OF HUSBAND OR WIFE August Kohlstaedt		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. None		
17. INFORMANT'S SIGNATURE OR NAME August Kohlstaedt		ADDRESS Wellington, Mo.				
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.						
MEDICAL CERTIFICATION						
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cardiac Decompensation				INTERVAL BETWEEN ONSET AND DEATH 14 day		
ANTECEDENT CAUSES DUE TO (b) Chronic myocardial degeneration				1 yr		
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (c) Arteriosclerosis				14 yr		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Hemiplegia & Hypertention				11 yr		
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		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 9-8-51, 19__, to 3-29-55, 19__, that I last saw the deceased alive on 3-26-55, 19__, and that death occurred at 3:40A m., from the causes and on the date stated above.						
23a. SIGNATURE <i>Dr. Wm. J. ...</i>			23b. ADDRESS D.O. Wellington, Mo.		23c. DATE SIGNED 3-29-55	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE March 31, 1955	24c. NAME OF CEMETERY OR CREMATORY St. Luke's Evangelical		24d. LOCATION (City, town, or county) (State) Wellington, Missouri	
DATE REC'D BY LOCAL REG. Nov. 29, 55		REGISTRAR'S SIGNATURE Emma Davidson		25. FUNERAL DIRECTOR'S SIGNATURE C. Sheppard ADDRESS Wellington, Mo.		

(Licensed Embalmer's Statement on Reverse Side)

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

540
1

1931
11/10

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 *J. Clair Shppard*

Licensed Embalmer No. *4179*

P. O. Address *Wellington,*

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.