

FILED APR 25 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 12070
1358
Registrar's No.

BIRTH NO. _____ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002

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. LENGTH OF STAY (in this place) 20 yrs.
c. CITY OR TOWN Kansas City d. Is Residence within limits of a city or incorporated town? Yes No

d. FULL NAME OF HOSPITAL OR INSTITUTION 4235 Locust-Rockhill Manor
STREET ADDRESS (If rural, give location) 4235 Locust 3659

3. NAME OF DECEASED (Type or Print) a. (First) MAUDE b. (Middle) J. J. c. (Last) MOSBACHER
4. DATE OF DEATH (Month) (Day) (Year) March 25 1955

5. SEX female 6. COLOR OR RACE white 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed
8. DATE OF BIRTH March 13, 1865 9. AGE (In years last birthday) 90 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (City and State or Foreign Country) Cleveland, Ohio / 12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME Frank Jones
13b. MOTHER'S MAIDEN NAME Elizabeth unknown
14. NAME OF HUSBAND OR WIFE Charles Mosbacher

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. No
17. INFORMANT'S SIGNATURE OR NAME ADDRESS Karl J. Mosbacher - Wichita, Kansas

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)
MEDICAL CERTIFICATION
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Thrombosis 9 days.
ANTECEDENT CAUSES
DUE TO (b) Cerebral Arteriosclerosis 4 Years.
DUE TO (c) General Arteriosclerosis 2.
II. OTHER SIGNIFICANT CONDITIONS
Bronchopneumonia 5 days.
*This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.
CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION 332
20. AUTOPSY? YES NO

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)
21e. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK
21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Nov. 1953, to 25 Mar., 1955, that I last saw the deceased alive on 25 Mar., 1955, and that death occurred at 11:25 P.M., from the causes and on the date stated above.

23a. SIGNATURE Philip G. Kaub (Degree or title) MD. 23b. ADDRESS 411 Nichols Road 23c. DATE SIGNED 26 Mar. 55

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal 24b. DATE 3/27/55 24c. NAME OF CEMETERY OR CREMATORY Wichita Park Cemetery 24d. LOCATION (City, town, or county) (State) Wichita, Kansas

DATE REC'D BY LOCAL REG. 3-26-55 REGISTRAR'S SIGNATURE Vera Marshall 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS STINE & McCLURE UND. CO. K.C.Mo.

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

10:15 - 10:45 -
P. O. 2000 City.

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.....
Robert H. Boyer

Licensed Embalmer No. 48

P. O. Address *K.C. 9, 1*

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.