

FILED SEP 14 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **26257**
3825

BIRTH NO. _____ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 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) <u>Kansas City</u>	c. LENGTH OF STAY (In this place) <u>61 days</u>	c. CITY OR TOWN <u>Kansas City</u>	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St. Luke's Hospital</u>		STREET ADDRESS (If rural, give location) <u>74 3 E. Concord 3748</u>	

3. NAME OF DECEASED (Type or Print) a. (First) <u>June</u> b. (Middle) <u>E.</u> c. (Last) <u>Kathrens</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>8-29-55</u>
---------------------------------------------------------------------------------------------------------------	---------------------------------------------------------

5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify!) <u>MARRIED</u>	8. DATE OF BIRTH <u>6-14-94</u>	9. AGE (In years last birthday) <u>61</u>	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) <u>RETIRED - PRESIDENT</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>KATHRENS MOVING & STORAGE CO.</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>KANSAS CITY, MISSOURI</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
--------------------------------------------------------------------------------------------------------------------------	-------------------------------------------------------------------------------	------------------------------------------------------------------------------------	-----------------------------------------------

13a. FATHER'S NAME <u>WILLIAM E. KATHRENS</u>	13b. MOTHER'S MAIDEN NAME <u>ANN M. ZANG</u>	14. NAME OF HUSBAND OR WIFE <u>ROSEMARY L. KATHRENS</u>
--------------------------------------------------	-------------------------------------------------	------------------------------------------------------------

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>491-22-3870</u>	17. INFORMANT'S SIGNATURE OR NAME (Type or Print) <u>Mrs Rosemary Kathrens</u>	ADDRESS <u>3 East Concord</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, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Arteriosclerotic Heart Disease with myocardial infarct</u>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		4200	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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 June 1939 to Aug 29 1955 that I last saw the deceased alive on Aug 29 1955 and that death occurred at 8:02 P.M., from the causes and on the date stated above.

23a. SIGNATURE <u>M. G. Berry M.D.</u>	23b. ADDRESS <u>315 Nichols Rd Kansas City</u>	23c. DATE SIGNED <u>Aug 30 55</u>
-------------------------------------------	---------------------------------------------------	--------------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	24b. DATE <u>SEPT-1-1955</u>	24c. NAME OF CEMETERY OR CREMATORY <u>CALVARY CEMETERY</u>	24d. LOCATION (City, town, or county) (State) <u>KANSAS CITY MISSOURI</u>
------------------------------------------------------------	---------------------------------	---------------------------------------------------------------	------------------------------------------------------------------------------

DATE REC'D BY LOCAL REG. <u>8-31-55</u>	REGISTRAR'S SIGNATURE <u>Neval Minshall</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>R.W. NEWCOMER'S SONS</u>	ADDRESS <u>1231 BRUSH CREEK KANSAS CITY, MO.</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, Student Embalmer No..... working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed *Rollie Kessel*.....

Licensed Embalmer No. *469*

P. O. Address *K.C.M.*

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.