

FILED AUG 23 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

26533

State File No. **3494**

BIRTH NO. _____		REG. DIST. NO. <u>149</u>		PRIMARY REG. DIST. NO. <u>1002</u>		Registrar's No. 3494			
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) 6 1/2 yrs.		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"/>			
d. FULL NAME OF HOSPITAL OR INSTITUTION 4415 E. 24 St.				STREET ADDRESS (If rural, give location) 34 4415 E. 24th St. 3348					
3. NAME OF DECEASED (Type or Print) a. (First) ALVENA			b. (Middle) ELIZA			c. (Last) TRETTER			
4. DATE OF DEATH (Month) (Day) (Year) Aug. 8, 1955		5. SEX Female		6. COLOR OR RACE white		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed			
8. DATE OF BIRTH Jan. 15, 1883		9. AGE (In years last birthday) 72		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) at home			10b. KIND OF BUSINESS OR INDUSTRY _____			11. BIRTHPLACE (City and State or Foreign Country) Missouri 0			
12. CITIZEN OF WHAT COUNTRY? USA				13a. FATHER'S NAME unknown		13b. MOTHER'S MAIDEN NAME unknown			
14. NAME OF HUSBAND OR WIFE George Henry Tretter				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. unk.			
17. INFORMANT'S SIGNATURE OR NAME Margaret L. Berglund				ADDRESS 4415 E. 24, 1955					
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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Hemorrhage ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Hypertension DUE TO (c) Cardiovascular Renal Syndrome 10/10 II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH 6 hours 10 min. 442 X	
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 April 7, 1950 to Aug 8, 1955 that I last saw the deceased alive on 8-8, 1955 and that death occurred at 10:45 p.m. , from the causes and on the date stated above.									
23a. SIGNATURE Wm. W. Thompson, D.O. (Degree or title) _____				23b. ADDRESS 628 Prospect, K.C.Mo		23c. DATE SIGNED 8-8-55			
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 8-8-55		24c. NAME OF CEMETERY OR CREMATORY _____		24d. LOCATION (City, town, or county) (State) Wellington, Missouri			
DATE REC'D BY LOCAL REG. 8-9-55		REGISTRAR'S SIGNATURE Neva Minshall		25. FUNERAL DIRECTOR'S SIGNATURE STINE & McCLURE UND. CO.		ADDRESS K.C.MO.			

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD Wm. W. Thompson

Dr. Thompson
6211 1/2

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. T. Crowell*

Licensed Embalmer No. *48*

P. O. Address *H.C. 2*

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.