

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms with registered. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

4713  
STATE FILE NUMBER  
407

FILED FEB 18 1957

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 407

1. PLACE OF DEATH a. COUNTY <b>JACKSON</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY <b>JACKSON</b>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>KANSAS CITY</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>KANSAS CITY</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital) HOSPITAL OR INSTITUTION <b>Trinity Lutheran</b>		Length of stay in 1b <b>3 yrs.</b>	d. STREET ADDRESS <b>3945 FOREST AVE</b> (If outside, give location)		Reside on Form Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>ANNA</b> Middle <b>GESTRING</b> Last <b>GESTRING</b>			4. DATE OF DEATH Month <b>JAN</b> Day <b>27</b> Year <b>1957</b>		
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>AUG 29 1870</b>	9. AGE (In years last birthday) IF UNDER 1 YEAR: Months <b>7</b> Days <b>18</b> Hours <b>20</b> Min. <b>86</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>IOWA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>CHARLES FURGEON</b>			14. MOTHER'S MAIDEN NAME <b>MARY WYKOF</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT <b>DR. HUGH H. GESTRING</b> Address <b>2233 JARBOE ST. KANSAS CITY MO.</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Cerebral Hemorrhage</b>					INTERVAL BETWEEN ONSET AND DEATH <b>7 hours</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Essential hypertension</b>					<b>Several yrs.</b>
DUE TO (c) <b>Arteriosclerosis</b>					<b>?</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Hour <b>7:25 p.</b> Month <b>1</b> Day <b>27</b> Year <b>1957</b>			20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION		COUNTY	STATE
21. I attended the deceased from <b>1-27-57</b> to <b>1-27-57</b> and last saw her <sup>her</sup> <sub>him</sub> alive on <b>1/27/57</b> Death occurred at <b>7:25 p.</b> on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <b>Joseph E. Welker MD</b>			22b. ADDRESS <b>836 Prof Bldg K.C. 6 Mo</b>		22c. DATE SIGNED <b>1/28/57</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>1-29-57</b>	23c. NAME OF CEMETERY OR CREMATORY <b>FOREST HILL CEMETERY</b>		23d. LOCATION (City, town, or county) (State) <b>KANSAS CITY MISSOURI</b>
24. FUNERAL DIRECTOR <b>D.W. NEWCOMER SONS</b>		ADDRESS <b>1331 R.C. MO</b>	25. DATE RECD. BY LOCAL REG. <b>1-28-57</b>		26. REGISTRAR'S SIGNATURE <b>new minshall</b>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Joseph E. Welker

**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 *Raymond M. Hardy*

Licensed Embalmer No. *49*

P. O. Address *Indep*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (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.