

FILED FEB 18 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

4757

STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 456

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, give TOWNSHIP only) OR TOWN Kansas City		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Kansas City		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Joseph Hospital		Length of stay in lb 31 Years	d. STREET ADDRESS 4005 Troost		(If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Frank Paul Middle HAUBER Last HAUBER			4. DATE OF DEATH Jan. 30 1957 Month Jan. Day 30 Year 1957		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 7, 1887	9. AGE (In years last birthday) 69 IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HRS.: Hour _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10b. KIND OF BUSINESS OR INDUSTRY WH Cooperage Co.	11. BIRTHPLACE (City and state or country) Lawrence, Kansas		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Frank J. Hauber			14. MOTHER'S MAIDEN NAME Barbara E. Knuehl		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW #1		16. SOCIAL SECURITY NO. 510-07-5792	17. INFORMANT Margaret Hauber, 4005 Troost, K.C. Mo. Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Rheumatic (mitral valve) heart disease					INTERVAL BETWEEN ONSET AND DEATH 2.5 yr.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.					DUE TO (b) _____ DUE TO (c) _____
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) London's of liver, Anemia, Diabetes Mellitus					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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 _____ Month _____ Day _____ Year _____ a. m. _____ p. m. _____					
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 Jan 1955 to Jan 30, 1957 and last saw ^{him} her alive on Jan 29, 1957 Death occurred at 2:00 a. m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE T Reid Jones (Degree or title) MD			22b. ADDRESS 411 Nichols Rd		22c. DATE SIGNED 1-30-57
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Feb. 1, 1957	23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		23d. LOCATION (City, town, or county) (State) Kansas City, Missouri
24. FUNERAL DIRECTOR Melody McGilley Eylar Funeral Home		ADDRESS Kansas City, Missouri		25. DATE RECD. BY LOCAL REG. 1-30-57	26. REGISTRAR'S SIGNATURE Neval Marshall

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Doctor, coroner, etc. must be casually related. Coroner cannot certify to a death due to natural causes. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes. All symptoms will be listed.

Dr. T. Reid Jones
411 Marshall Rd.
VA - 1330
- 5 PM

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 *James E. Kachler*

Licensed Embalmer No. *43*

P. O. Address *K.C. 4*

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.