

FILED APR 16 1957

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER 1512

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

S. 300  
1-57

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

Fred H. Lundgren, J.E. USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. Mary's Hospital</b>		Length of stay in lb <b>35 Yrs.</b>	d. STREET ADDRESS (If outside, give location) <b>2104 E. 42nd. K. C. Mo</b>
3. NAME OF DECEASED (Type or print) First <b>Dorothy</b> Middle <b>Francis</b> Last <b>Wigg</b>		4. DATE OF DEATH Month <b>March</b> Day <b>27</b> Year <b>1957</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 17 1899</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 <b>Domestic</b>	11. BIRTHPLACE (City and state or country) <b>Kansas City, Kansas</b>
13a. FATHER'S NAME <b>John Gelchrist</b>		13b. MOTHER'S MAIDEN NAME <b>Dora Broan</b>	14. NAME OF HUSBAND OR WIFE <b>Philip A. Wigg</b>
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>487 05 2649</b>	17. INFORMANT Address <b>Philip A. Wigg - 2104 E. 42nd. K. C. 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>Hemorrhage from aneurysmal transplant</b> DUE TO (b) <b>Peri-nephric abscess</b> DUE TO (c) <b>(c) Aortic aneurysm, atherosclerosis</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b> <b>15 days</b> <b>45X</b>
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 <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>May 1952</b> to <b>27 March 57</b> and last saw her alive on <b>27 March 1957</b> Death occurred at <b>5:20 PM</b> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <b>0</b> <b>Fred H. Lundgren Jr MD</b>		22b. ADDRESS <b>315 Nichols Rd. K.C. Mo.</b>	22c. DATE SIGNED <b>3/29/57</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>3-30-57</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Floral Hills</b>	23d. LOCATION (City, town, or county) (State) <b>Kansas City Missouri</b>
24. FUNERAL DIRECTOR ADDRESS <b>FLORAL HILLS MEM CHAPEL INC * K.C.MO</b>		25. DATE RECD. BY LOCAL REG. <b>3-30-57</b>	26. REGISTRAR'S SIGNATURE <b>Neva Minshall</b>

*Boyer*

*Nov 1 - 1983*

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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 *Everett S. Seal*

Licensed Embalmer No. *4864*

P. O. Address *Ferris City*

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.