

FILED JUN 5 1957

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

16978  
STATE FILE NUMBER  
2276

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

S. 300  
v. 1-57

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, give TOWNSHIP only) OR TOWN <u>Kansas City</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		8 CITY OR TOWN <u>Kansas City</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>812 W. 67 St. Terr</u>			Length of stay in 1b <u>49 yrs.</u>		STREET ADDRESS (If outside, give location) <u>St Regis Hotel</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>Leonard</u> Middle <u>A.</u> Last <u>Calkins</u>				4. DATE OF DEATH Month <u>May</u> Day <u>16</u> Year <u>1957</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb. 15, 1891</u>		9. AGE (In years) <u>66</u> IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Treasurer</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Katz Drug Co.</u>		11. BIRTHPLACE (City and state or country) <u>Hamburg Iowa</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13a. FATHER'S NAME <u>Chauncy Calkins</u>				13b. MOTHER'S MAIDEN NAME <u>Louise Leitz</u>			14. NAME OF HUSBAND OR WIFE _____		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>yes 10-11-1</u>			16. SOCIAL SECURITY NO. <u>486-09-1762</u>		17. INFORMANT Address <u>Mr. Arthur J. Daniel 812 W 67 Th Terr</u>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> <u>Coronary thrombosis</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) <u>atherosclerosis</u>							INTERVAL BETWEEN ONSET AND DEATH <u>stroke death</u> <u>4201</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Chronic coronary insufficiency + angina</u>							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 _____ 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 <u>1951</u> to <u>5-16-57</u> and last saw her alive on <u>5-15-57</u> . Death occurred at <u>11:30 p.m.</u> on the date stated above; and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Degree or title) <u>William Lowe Mundy M.D.</u>				22b. ADDRESS <u>1103. Grand</u>			22c. DATE SIGNED <u>5-17-57</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>5/18/57</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Shawnee Cemetery</u>			23d. LOCATION (City, town, or country) (State) <u>Shawnee Kas.</u>		
24. FUNERAL DIRECTOR <u>Stine &amp; McClure K. C. Mo.</u>				25. DATE RECD. BY LOCAL REG. <u>5-17-57</u>		26. REGISTRAR'S SIGNATURE <u>Neva Marshall</u>			

MEDICAL CERTIFICATION  
Mundy ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
William Lowe

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.

No. 2-4075  
10.30 AM/3 PM

KP  
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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 *R. C. M. O.* .....

Licensed Embalmer No. *3938* .....

P. O. Address *K. C. Mo* .....

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.