FILED AUG 15 1957

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER 24790

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 3594

1. PLACE OF DEATH
a. COUNTY Jackson
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City — Inside Limits Yes ☒ No ☐
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Joseph's Hosp. — Length of stay in 1b 32 yrs

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY Jackson
c. CITY OR TOWN Kansas City — Inside Limits Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location) 3228 Kensington — Reside on Farm Yes ☐ No ☒

3. NAME OF DECEASED (Type or print) First: LILLIAN Middle: Last: RENSKERS

4. DATE OF DEATH Month: July Day: 30 Year: 1957

5. SEX Female

6. COLOR OR RACE White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH Dec. 1, 1895

9. AGE (In years last birthday) 61 — 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) Housewife

10b. KIND OF BUSINESS OR INDUSTRY Home

11. BIRTHPLACE (City and state or country) Tennessee

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13a. FATHER'S NAME John Nelson

13b. MOTHER'S MAIDEN NAME Margaret Anderson

14. NAME OF HUSBAND OR WIFE John Renskers

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. None.

17. INFORMANT John Renskers, 3228 Kensington Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Hypertension
DUE TO (c) Senility — 331+
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Diabetes Mellitus

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

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 6-1-49, to 7-30-57 and last saw her/him alive on 7-29-57
Death occurred at [illegible] on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Hugh A. Gestring (Degree or title)

22b. ADDRESS 1220 E 31st St. KCMo.

22c. DATE SIGNED

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial

23b. DATE 8-1-1957

23c. NAME OF CEMETERY OR CREMATORY Mt. Washington Cem.

23d. LOCATION (City, town, or county) (State) Kansas City, Missouri

24. FUNERAL DIRECTOR Mellody-McGilley-Eylar Funeral Home ADDRESS 1800 E. Linwood, K. C., Mo. (Licensed Embalmer's Statement on Reverse Side)

25. DATE RECD. BY LOCAL REG. 7-31-57

26. REGISTRAR'S SIGNATURE Neva Minshall

All diseases in Part I must be causally related. USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Hugh A. Gestring

Dr Hugh Gev
1220 E. 31
Vale 1-6400

1-PM-5:

KP 2

VS JUN 10 1960

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 Arthur Eugene Hook

Licensed Embalmer No. 4912

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.