

**THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH**

State File No. **28200**

FILED AUG 30 1957

No. 300
10-48

BIRTH NO. _____		REG. DIST. NO. <u>147</u>		PRIMARY REG. DIST. NO. <u>1002</u>		Registrar's No. <u>3724</u>	
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>Lafayette</u>			
b. CITY (If outside corporate limits, write RURAL and give OR TOWN <u>Kansas City</u>)		c. LENGTH OF STAY (In this place) <u>4 days</u>		c. CITY OR TOWN <u>Higginsville</u>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St. Lukes Hosp: Tal-</u>				*e. STREET ADDRESS (If rural, give location) <u>105 E 14th</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Mary</u> b. (Middle) <u>—</u> c. (Last) <u>Breipohl</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>Aug. 8-1957</u>				
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED NEVER MARRIED <u>WIDOWED</u> DIVORCED SEPARATED		8. DATE OF BIRTH <u>Oct. 23-1875</u>	
9. AGE (In years last birthday) <u>81</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>Higginsville, Missouri</u>	
10a. USUAL OCCUPATION		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Henry Wolkwitz</u>			13b. MOTHER'S MAIDEN NAME <u>Witter</u>			14. NAME OF HUSBAND OR WIFE <u>William Breipohl</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mrs. Aileen Breipohl 4551 Main. K.C., MO.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION			
				I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Myocardial Infarction</u>		INTERVAL BETWEEN ONSET AND DEATH <u>29 hrs.</u>	
				ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Arteriosclerotic heart disease</u>			
				DUE TO (c) _____			
				II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		<u>4:00</u>	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) _____			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? _____			
22. I hereby certify that I attended the deceased from <u>Aug 5</u> , 1957, to <u>Aug 8</u> , 1957, that I last saw the deceased alive on <u>Aug 8</u> , 1957, and that death occurred at <u>11:55 A.M.</u> , from the causes and on the date stated above.							
23a. SIGNATURE <u>John B. Justus M.D.</u> (Degree or title)				23b. ADDRESS <u>4620 Nichols Hwy K.C., MO</u>		23c. DATE SIGNED <u>Aug 9, '57</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		24b. DATE <u>Aug. 9, 1957</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Brand Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Kansas City, Higginsville, MO.</u>	
DATE REC'D BY LOCAL REG. <u>8-9-57</u>		REGISTRAR'S SIGNATURE <u>Neva Marshall</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>C.H. Blackman & Son Inc. N.C. Mo.</u>			

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD
John B. Justus



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 *W. C. Purine*.....

Licensed Embalmer No. *489*.....

P. O. Address *K. E. M.*.....

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.