Health, Welfare Public Service

300
1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Hugh H. Owens

FILED OCT 24 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER 35909

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4585

1. PLACE OF DEATH
a. COUNTY: Jackson
b. CITY OR TOWN: Kansas City — Inside Limits: Yes [X] No [ ]
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location): 2544 Forest Ave — Length of stay in Hospital: 55 hrs

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MO b. COUNTY: Jackson
c. CITY OR TOWN: Kansas City — Inside Limits: Yes [X] No [ ]
d. STREET ADDRESS (If outside, give location): 2544 Forest Ave — Reside on Farm: Yes [ ] No [X]

3. NAME OF DECEASED (Type or print): First: Logan Middle: Last: Imhoff

4. DATE OF DEATH Month Day Year: 10-3-1957

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED [ ] **NEVER MARRIED** [ ] **WIDOWED** [ ] **DIVORCED** [X]

8. DATE OF BIRTH: 7-4-1874

9. AGE (In years last birthday): 83

IF UNDER 1 YEAR: Months Days Hours Min.
IF UNDER 24 HRS.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): FIREMAN

10b. KIND OF BUSINESS OR INDUSTRY: RAILROAD

11. BIRTHPLACE (City and state or country): MORPHY BORO, ILL

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: AUGUSTUS IMHOFF

14. MOTHER'S MAIDEN NAME: UNKNOWN

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.: UNK

17. INFORMANT: TOM ROBERTS Address: JOPLIN, MO

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) Arteriosclerotic Heart Disease
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b)
DUE TO (c)
INTERVAL BETWEEN ONSET AND DEATH: 42 yrs

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Hiatary Hernia

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

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 _____ to _____ and last saw her/him alive on _____
Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): Hugh H. Owens Coroner

22b. ADDRESS: 1034 Rialto Bldg

22c. DATE SIGNED: 10-3-57

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

23b. DATE: 10-3-1957

23c. NAME OF CEMETERY OR CREMATORY

23d. LOCATION (City, town, or county) (State): CARTHAGE, MO

24. FUNERAL DIRECTOR ADDRESS: ULMER FUNERAL HOME CARTHAGE, MO

25. DATE RECD. BY LOCAL REG.: 10-3-57

26. REGISTRAR'S SIGNATURE: Neva Minshall

(Licensed Embalmer's Statement on Reverse Side)

KP 2

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was em

by me, or by ....., Student Embalmer No.....

working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed Leonard Passantino

Licensed Embalmer No. 45

P. O. Address KCM

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (F
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.