

pt. Health,  
, & Welfare  
S. Public  
alth Service

FILED DEC 18 1957

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

44448  
STATE FILE NUMBER  
5715

Registration District No. 149 Primary Registration District No. 1002

Registrar's No. 5715

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>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF DECEASED (If NOT in hospital, give location) <b>512 Woodland</b> HOSPITAL OR INSTITUTION <b>Woodland Nursing Home</b>		Length of stay in lb <b>71 yrs</b>	d. STREET ADDRESS (If outside, give location) <b>512 Woodland</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>ANNA</b> Middle <b>S.</b> Last <b>KUNZWEILER</b>			4. DATE OF DEATH Month <b>Dec.</b> Day <b>1</b> Year <b>1957</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 1, 1865</b>	9. AGE (In years last birthday) <b>92</b>	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) <b>Tentmaker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Carnie Goudy Co.</b>		11. BIRTHPLACE (City and state or country) <b>Tipton, Missouri</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		13a. FATHER'S NAME <b>Wm. Lutz</b>		13b. MOTHER'S MAIDEN NAME <b>Lena Beckerer</b>	
14. NAME OF HUSBAND OR WIFE <b>Wm. Kunzweiler</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>500-03-7088-A</b>		17. INFORMANT <b>Sena</b> Address <b>Mrs. Musslyn, 3416 Wayne</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>Arteriosclerosis</b> DUE TO (b) <b>Arterio sclerosis</b> DUE TO (c) 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>5 yrs</b> <b>3 yrs</b> <b>4500</b>
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 WORK <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 Death occurred at <b>7:07 AM</b> on <b>1-1-57</b> to <b>12-1-57</b> and last saw her alive on <b>12-1-57</b> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22. SIGNATURE (Degree or title) <b>Frank Paul Laureanza MD</b>			22b. ADDRESS <b>4285 White Ave</b>		22c. DATE SIGNED <b>12-1-57</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>12-4-1957</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Calvary</b>		23d. LOCATION (City, town, or county) (State) <b>Kansas City, Missouri</b>
24. FUNERAL DIRECTOR <b>Mellody-McGilley-Eylar Funeral Home</b>		ADDRESS <b>1800 E. Linwood, K. C., Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>12-3-57</b>	26. REGISTRAR'S SIGNATURE <b>Neval Marshall</b>

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.

Frank Paul Laureanza MD  
MEDICAL CERTIFICATION  
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

To Frank Paul Lewis  
428 S. White  
Be 1-3319

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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 *Arthur Eugene Hook*

Licensed Embalmer No. *4912*  
P. O. Address *NCMO*

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.