

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

44580

STATE FILE NUMBER

FILED JAN 8 1958

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 5898

| | | | | | |
|--|------------------------------|---|--|---|---|
| 1. PLACE OF DEATH a. COUNTY Jackson | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Jackson | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | c. CITY OR TOWN Kansas City | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Research Hosp. | | Length of stay in lb 4 yrs | d. STREET ADDRESS 5401 Brookside (If outside, give location) | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First OLIVER Middle S. Last RUNDELL | | | 4. DATE OF DEATH Month 12 Day 12 Year 57 | | |
| 5. SEX Ma | 6. COLOR OR RACE Wh | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 10-6-1881 | 9. AGE (In years last birthday) 76 | 10. UNDER 1 YEAR Months 12 Days 12 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher | | 10b. KIND OF BUSINESS OR INDUSTRY Law School | 11. BIRTHPLACE (City and state or country) Rewey, Wisconsin | | 12. CITIZEN OF WHAT COUNTRY? USA |
| 13a. FATHER'S NAME Hiram A. Rundell | | 13b. MOTHER'S MAIDEN NAME Angeline Livingston | | 14. NAME OF HUSBAND OR WIFE Mrs. Abigail E. Rundell | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, name of unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 394-18-3865 | 17. INFORMANT Address Mrs. Abigail E. Rundell, 5401 Brookside | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction | | | | | INTERVAL BETWEEN ONSET AND DEATH 2 days |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) arteriosclerotic coronary thrombosis | | | | | 3 wks. |
| DUE TO (c) _____ | | | | | 4201 |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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 _____ a.m. _____ p.m. | | | 20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | |
| 20e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 20f. CITY, TOWN, OR LOCATION COUNTY STATE | | |
| 21. I attended the deceased from Nov 1957 to Dec 1957 and last saw her alive on 12/12/57 Death occurred at 2:00 P.M. on the date stated above; and to the best of my knowledge, from the causes stated. | | | | | |
| 22a. SIGNATURE John W. Cashman, MD (Degree or title) | | | 22b. ADDRESS 535 Argyle Bldg KC Mo | | 22c. DATE SIGNED 12/12/57 |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Removal | 23b. DATE 12-13-57 | 23c. NAME OF CEMETERY OR CREMATORY Forest Hill | | 23d. LOCATION (City, town, or county) (State) Madison, Wis. | |
| 24. FUNERAL DIRECTOR Wagner Funeral Home, K 6 Mo ADDRESS | | | 25. DATE RECD. BY LOCAL REG. 12-13-57 | 26. REGISTRAR'S SIGNATURE Neva Minshall | |

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.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION
John W. Cashman

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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 *Alvin R. Haunschild*

Licensed Embalmer No. *4159*

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.