

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH1293
STATE FILE NUMBER

FILED FEB 13 1958

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 320

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 809 No Agnes		Length of stay in 6 wks	d. STREET ADDRESS (If outside, give location) 809 No Agnes		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First EDNA Middle KAMMER Last KAMMER			4. DATE OF DEATH Month January , Day 20 Year 1958		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 11 1906	9. AGE (In years last birthday) 51	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Houskeeper		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Cincinnati Ohio		12. CITIZEN OF WHAT COUNTRY? USA
13a. FATHER'S NAME Martin J Kammer		13b. MOTHER'S MAIDEN NAME Katherine Coleman		14. NAME OF HUSBAND OR WIFE USA	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 270-01-4305	17. INFORMANT Address Rev Alcuin Kammer 809 No Agnes K C mo		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema					INTERVAL BETWEEN ONSET AND DEATH 6 hours
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.					
DUE TO (b) Myocardial Insufficiency					2 years
DUE TO (c) Myocarditis					3 years
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 <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 <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 Jan 6, 1958 , to Jan 17, 1958 and last saw her alive on Jan 17, 1958 Death occurred at _____ on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) Dr. A. C. Cacioppo D.O.			22b. ADDRESS 2717 Rockster Kansas City Mo		22c. DATE SIGNED 1-22-58
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)
Burial Removal 1/22/58			-		Cincinnati Ohio
24. FUNERAL DIRECTOR ADDRESS Shell Funeral Home Kansas City Mo		25. DATE RECD. BY LOCAL REG. 1-22-58		26. REGISTRAR'S SIGNATURE neva minshall	

(Licensed Embalmer's Statement on Reverse Side)

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
A. C. Cacioppo300
1-57

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 Thomas A. Phil

Licensed Embalmer No. 4954

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.