

FILED APR 2 1958

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-009947  
STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 1344

300  
1-57

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 (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>1609 Elmwood</b>		Length of stay in lb <b>45 yrs.</b>	d. STREET ADDRESS (If outside, give location) <b>1609 Elmwood</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Luella</b> Middle <b>B.</b> Last <b>Gerhardt</b>			4. DATE OF DEATH Month <b>Mar.</b> Day <b>12,</b> Year <b>1958</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>Sept. 27, 1872</b>		9. AGE (In years last birthday) <b>85</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>--</b>	11. BIRTHPLACE (City and state or country) <b>Keytsville, Missouri</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>
13a. FATHER'S NAME <b>Thomas Burgoon</b>		13b. MOTHER'S MAIDEN NAME <b>Martha Kincaid</b>		14. NAME OF HUSBAND OR WIFE <b>Louis Gerhardt</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>none</b>	17. INFORMANT <b>Ruth Smith</b> Address <b>2107 Quindaro Blvd.</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>Carcinoma of Colon</b>					INTERVAL BETWEEN ONSET AND DEATH <b>6 mos - 1538</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (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) <b>Chronic Myocarditis - Generalized Arteriosclerosis</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.) <b>2</b>			
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 <b>Aug 57</b> to <b>3-12-58</b> and last saw her alive on <b>3-12-58</b> Death occurred on <b>3-12-58</b> at <b>11:50 P.M.</b> in <b>St. Albans</b> on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <b>Paul A. Kienberger MD</b> (Degree or title)			22b. ADDRESS <b>5246 ft John</b>		22c. DATE SIGNED <b>3-14-58</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>3/15/58</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mt. St. Mary's Ceme.</b>		23d. LOCATION (City, town, or county) (State) <b>Kansas City, Missouri</b>	
24. FUNERAL DIRECTOR <b>Earp &amp; Sons 4707 Truman Rd.</b>		ADDRESS		25. DATE RECD. BY LOCAL REG. <b>3-14-58</b>	26. REGISTRAR'S SIGNATURE <b>Neva 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.

Paul A. Kienberger  
MEDICAL CERTIFICATION  
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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 ..... *William H. Egan* .....

Licensed Embalmer No. *4728* .....

P. O. Address *Ke 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.