

FILED MAY 9 1958

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-014285  
STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 1990

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Lafayette</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kansas City</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Concordia</u>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St Joseph Hospital</u>		Length of stay in 1b <u>10 days</u>	d. STREET ADDRESS (If outside, give location) <u>X</u>
		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>EMMA</u> Middle <u></u> Last <u>KUHLMAN</u>			4. DATE OF DEATH Month <u>April</u> Day <u>17</u> Year <u>1958</u>		
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5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>August 28 1874</u>	9. AGE (In years last birthday) <u>83</u>	10. UNDER 1 YEAR Months <u></u> Days <u></u>	11. UNDER 24 HRS. Hours <u></u> Min. <u></u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	11. BIRTHPLACE (City and state or country) <u>Concordia Mo</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
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13a. FATHER'S NAME <u>William Walkerhart</u>	13b. MOTHER'S MAIDEN NAME <u>Unknown</u>	14. NAME OF HUSBAND OR WIFE <u>Joe Kuhlman</u>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>	16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT <u>Miss Kathryn Kuhlman Pittsburgh Pa</u>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic heart disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Chronic</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Arteriosclerosis</u>	
	DUE TO (c) <u></u>	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Fracture of left hip</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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20a. ACCIDENT <input checked="" 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.) <u>Accidental fall</u>
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20c. TIME OF INJURY Hour <u></u> Month <u>4</u> Day <u>7</u> Year <u>58</u> a.m. <u></u> p.m. <u></u>	
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20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Home</u>	20f. CITY, TOWN, OR LOCATION <u>Concordia</u>	COUNTY <u>Lafayette</u>	STATE <u>Mo</u>
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21. I attended the deceased from <u>4/7/58</u> to <u>4/17/58</u> and last saw her alive on <u>4/17/58</u> Death occurred at <u>or about</u> <u>8:00 pm</u> on the date stated above; and to the best of my knowledge, from the causes stated.	
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22a. SIGNATURE <u>Herbert A. Hamel, M.D.</u>	(Degree or title)	22b. ADDRESS <u>16306 Morningside K.C. Mo</u>	22c. DATE SIGNED <u>4/18/58</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>April 20, 1958</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Concordia Mo</u>	23d. LOCATION (City, town, or county) (State) <u>Concordia Missouri</u>
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24. FUNERAL DIRECTOR <u>James Funeral Home</u>	ADDRESS <u>Concordia Mo 4-18-58</u>	25. DATE RECD. BY LOCAL REG. <u>reva minshall</u>	26. REGISTRAR'S SIGNATURE
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(Licensed Embalmer's Statement on Reverse Side)

MEDICAL CERTIFICATION

Herbert A. Hamel

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

300  
1-57

All diseases in Part I must be causally related.

1990

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 *Chas E Wilks* .....

Licensed Embalmer No. *2644* .....  
P. O. Address *X 8 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.

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