

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.

THE DIVISION OF HEALTH OF MISSOURI  
**STANDARD CERTIFICATE OF DEATH**

**58-014342**  
 STATE FILE NUMBER  
**1954**

FILED MAY 9 1958

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. \_\_\_\_\_

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>903 W. 75th STREET</b>		Length of stay in 1b <b>45 YEARS</b>	d. STREET ADDRESS (If outside, give location) <b>903 WEST 75th STREET</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>ADOLPH</b> Middle <b>D.</b> Last <b>MOHR</b>			4. DATE OF DEATH Month <b>APRIL</b> Day <b>13</b> Year <b>1958</b>		
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>MAY 21 1884</b>	
9. AGE (In years at birthday) <b>73</b>		IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____		IF UNDER 24 HRS. Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FLORIST-ADOLPH MOHR</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>FLOWERS - GREENHOUSE</b>		11. BIRTHPLACE (City and state or country) <b>GERMANY</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13a. FATHER'S NAME <b>DETIAF MOHR</b>		13b. MOTHER'S MAIDEN NAME <b>ANNA THURMAN</b>	
14. NAME OF HUSBAND OR WIFE <b>MARGUERITE MOHR</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>497-36-4522</b>	
17. INFORMANT <b>WALTER H. MOHR</b>		Address <b>7609 WASHINGTON KANSAS CITY, MO</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>Acute Myocardial Infarction</b> DUE TO (b) <b>Arteriosclerotic Heart Disease</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>45 minutes</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 _____ a.m. _____ p.m. Month, Day, Year _____			
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.) <b>Kansas City</b>		20f. CITY, TOWN, OR LOCATION <b>Jackson</b> COUNTY <b>Jackson</b> STATE <b>Missouri</b>	
21. I attended the deceased from Death occurred at <b>June 12 1958</b> to <b>April 13, 1958</b> and last saw him alive on <b>4. 13. 58</b> at <b>10:20 P. m.</b> on the date stated above; and to the best of my knowledge, from the causes stated.		22a. SIGNATURE <b>F. Stanley Mores</b> (Degree or title)		22b. ADDRESS <b>4620 Nichols Plany</b>	
22c. DATE SIGNED <b>4/14/58</b>		23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>APRIL 16 1958</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>MT. MORIAN CEMETERY</b>		23d. LOCATION (City, town, or country) (State) <b>KANSAS CITY MISSOURI</b>		24. FUNERAL DIRECTOR <b>D.W. NEWCOMERS SONS</b> ADDRESS <b>133 BRUSH CREEK KANSAS CITY, MO</b>	
25. DATE RECD. BY LOCAL REG. <b>4-16-58</b>		26. REGISTRAR'S SIGNATURE <b>neva Marshall</b>			

MEDICAL CERTIFICATION  
 USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
 F. Stanley Mores



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 ..... *W. J. Selman* .....

Licensed Embalmer No. *4421* .....  
P. O. Address *Kansas City* .....

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.