

Health,
& Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-018453
STATE FILE NUMBER
2684

FILED JUN 11 1958 Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 2684

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
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION ST. LUKE'S HOSPITAL		Length of stay in 1b 58 YEARS	d. STREET ADDRESS (If outside, give location) 1017 WEST 67th STREET

3. NAME OF DECEASED (Type or print) First MIDDLE Last EUGENE CHRIS REPPERT	4. DATE OF DEATH Month Day Year MAY - 24 1958
--	---

5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 15, 1885	9. AGE (In years (last birthday)) 72	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) MOTOR CAR DEALER	10b. KIND OF BUSINESS OR INDUSTRY Automobile Sales	11. BIRTHPLACE (City and state or country) Burlington, Iowa	12. CITIZEN OF WHAT COUNTRY? U. S. A.
---	---	--	--

13a. FATHER'S NAME CHRISTIAN REPPERT	13b. MOTHER'S MAIDEN NAME ELIZABETH TELLAZARRO	14. NAME OF HUSBAND OR WIFE LOTTIE REPPERT
---	---	---

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, or (if unknown)) (If yes, give war or dates of service) NO	16. SOCIAL SECURITY NO. NONE	17. INFORMANT MRS. LOTTIE REPPERT	Address 1017 W. 67th ST. KANSAS CITY, 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) Cerebral Embolus		INTERVAL BETWEEN ONSET AND DEATH 10 hrs.	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Pulmonary Infarction		2-3 days
	DUE TO (c) Arterio-sclerotic Heart disease		days.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Carcinoma of the Lung - metastatic		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.) 4200 H
---	--

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 5-4-58 to 5-24-58 and last saw him alive on 5/24/58 Death occurred at 8:45 A.M. 5/24/58 in the date stated above; and to the best of my knowledge, from the causes stated.	22a. SIGNATURE (Degree or title) Arnold V. Arms	22b. ADDRESS 4635 Wyandotte R City Mo	22c. DATE SIGNED 5/26/58
--	--	--	-----------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE MAY 27, 1958	23c. NAME OF CEMETERY OR CREMATORY MT. MORIAH	23d. LOCATION (City, town, or county) (State) KANSAS CITY, MISSOURI
---	---------------------------	--	--

24. FUNERAL DIRECTOR D.W. NEWCOMER'S SONS. 1331 BRUSH CREEK KANSAS CITY, MO.	25. DATE RECD. BY LOCAL REG. 5-27-58	26. REGISTRAR'S SIGNATURE neva marshall
---	---	--

(Licensed Embalmer's Statement on Reverse Side)

MEDICAL CERTIFICATION
Arnold V. Arms USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

300
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 *[Handwritten Signature]*

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.