

Health,  
Welfare  
Public  
Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-018523  
STATE FILE NUMBER

FILED JUN 11 1958 Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 2710

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>Kansas</b> b. COUNTY <b>Miami</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kansas City</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Louisburg</b> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. Mary's Hosp.</b>		Length of stay in lb <b>4 Mo.</b>	d. STREET ADDRESS (If outside, give location) <b>41508</b> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>Gertrude</b> Middle <b>M.</b> Last <b>Spielbusch</b>			4. DATE OF DEATH Month <b>5-26-</b> Year <b>1958</b>	
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5. SEX <b>female</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>1-22-1898</b>	9. AGE (In years last birthday) <b>60</b>	10. FUNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/>	11. IF UNDER 24 HRS. Hours <input type="checkbox"/> Min. <input type="checkbox"/>
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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	11. BIRTHPLACE (City and state or country) <b>Louisburg, Kans.</b>	12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>
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13a. FATHER'S NAME <b>George Seufferling</b>	13b. MOTHER'S MAIDEN NAME <b>Veronica</b>	14. NAME OF HUSBAND OR WIFE <b>Raymond Spielbusch</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give year or dates of service) <b>no</b>	16. SOCIAL SECURITY NO. <b>none</b>	17. INFORMANT <b>Raymond Spielbusch</b>	Address <b>Louisburg, Kans.</b>
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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) <b>cardiac failure</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 hrs.</b>
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Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>papillary carcinoma of ovary with metastasis</b>	?
	DUE TO (c) <b>carcinoma of ovary with peritoneal metastasis</b>	<b>1750</b>

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Operation Feb. 1958</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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.)
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20c. TIME OF INJURY Hour <input type="checkbox"/> Month, Day, Year a.m. <input type="checkbox"/> p.m. <input type="checkbox"/>	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
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21. I attended the deceased from <b>Feb. 1, 1958</b> to <b>May 26 -58</b> and last saw her alive on <b>May 26-58</b> Death occurred at <b>9:10A.</b> m on the date stated above; and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE <b>Donald R. Davis M.D.</b>	22b. ADDRESS <b>4706 Broadway K. C. Mo.</b>	22c. DATE SIGNED <b>5-26-58</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>removal</b>	23b. DATE <b>5-29-58</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Louisburg, Catholic</b>	23d. LOCATION (City, town, or country) (State) <b>Louisburg, Kans.</b>
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24. FUNERAL DIRECTOR <b>Rynyan Funeral Home</b>	ADDRESS <b>Louisburg, Kans.</b>	25. DATE RECD. BY LOCAL REG. <b>5-28-58</b>	26. REGISTRAR'S SIGNATURE <b>neva minshall</b>
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(Licensed Embalmers' Statement on Reverse Side)

Donald R. Davis M.D. Use GAY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION  
All diseases in Part I must be causally related.

MAY 12 1959

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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. *Gerald E. White*

Licensed Embalmer No. *495*

P. O. Address *Spaulding*

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.