Health, Welfare Public Service

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THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

58-018577
STATE FILE NUMBER

FILED JUN 11 1958 Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 2707

1. PLACE OF DEATH
a. COUNTY: Jackson
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: Kansas City — Inside Limits: Yes [X] No [ ]
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: Gen'l Hosp. #1 — Length of stay in 1b: 14 Years

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri
b. COUNTY: Jackson
c. CITY OR TOWN: Kansas City — Inside Limits: Yes [X] No [ ]
d. STREET ADDRESS (If outside, give location): 3224 Campbell — Reside on Farm: Yes [ ] No [X]

3. NAME OF DECEASED (Type or print): First: Louise — Middle: VanDe Wiele — Last: ##########
4. DATE OF DEATH: Month 5 Day 28 Year 1958
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH: 8/23/1898
9. AGE (In years last birthday): 59 — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework
10b. KIND OF BUSINESS OR INDUSTRY: At Home
11. BIRTHPLACE (City and state or country): Belgium
12. CITIZEN OF WHAT COUNTRY?: U.S.A.
13a. FATHER'S NAME: Amandus DeWilde
13b. MOTHER'S MAIDEN NAME: Don't Know
14. NAME OF HUSBAND OR WIFE: Gilbert VanDe Wiele
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: Don't Know
17. INFORMANT: Gilbert VanDeWiele, 3224 Campbell, K.C. Mo.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Pericarditis due to Lobar Pnuemonia — INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): Left Lung
DUE TO (c): 490X
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)
19. WAS AUTOPSY PERFORMED? YES [ ] NO [ ]

20a. ACCIDENT [ ] SUICIDE [ ] HOMICIDE [ ]
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 WORK [ ] NOT WHILE AT WORK [ ]
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 May 26, 1958, to May 28, 1958 and last saw her/him alive on May 28, 1958
Death occurred at 2:05 A.m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: B. I. Burns, M.D. (Degree or title)
22b. ADDRESS: 24th & Cherry
22c. DATE SIGNED: 5-28-58

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal
23b. DATE: 5/28/1958
23c. NAME OF CEMETERY OR CREMATORY: St. Mary's Cemetery
23d. LOCATION (City, town, or county) (State): St. Mary's, Kansas

24. FUNERAL DIRECTOR — ADDRESS: Jos. A. Butler's Sons, K.C.K.
25. DATE RECD. BY LOCAL REG.: 5-28-58
26. REGISTRAR'S SIGNATURE: Neva Marshall

(Licensed Embalmer's Statement on Reverse Side)

All diseases in Part I must be causally related. USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

B. I. Burns

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 .....

Licensed Embalmer No. 3426 Missc

P. O. Address Kansas City 2, Kar

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.