

FILED JUL 30 1958

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-025592

STATE FILE NUMBER

3420

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 3420

S. 300

1-57

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Kansas b. COUNTY Johnson	
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 Fairway 8156
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St Lukes Hosp.		Length of stay in hospital 5 wks Hougers	d. STREET ADDRESS (If outside, give location) 5515 Fairway
3. NAME OF DECEASED (Type or print) First Augusta Middle Marie Last Kasten		4. DATE OF DEATH Month July Day 13 Year 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 10, 1872
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		9b. KIND OF BUSINESS OR INDUSTRY	9c. AGE (In years last birthday) 85
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) Germany	12. CITIZEN OF WHAT COUNTRY? U. S. A.
13a. FATHER'S NAME Unknown Ratzloff		13b. MOTHER'S MAIDEN NAME Unknown	14. NAME OF HUSBAND OR WIFE Fred Kasten
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none	17. INFORMANT Mrs. A. K. Beyer 5515 Fairway
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia DUE TO (b) Cerebral Thrombosis DUE TO (c) Arteriosclerosis 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 3 3/4 X
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.		20d. INJURY OCCURRED WHILE AT WORK <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 Death occurred at 10 AM 6-18-58 to 7-13-58 and last saw her alive on 7-12-58 m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Robert K. Skillman M.D.		22b. ADDRESS 4635 Wyandotte	
22c. DATE SIGNED 7-14-58			
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 7/15/58	
23c. NAME OF CEMETERY OR CREMATORY Merrill Cemetery		23d. LOCATION (City, town, or country) (State) Merrill Wisconsin	
24. FUNERAL DIRECTOR Stine & McClure		25. DATE RECD. BY LOCAL REG. 7-14-58	
ADDRESS K. C. Mo.		26. REGISTRAR'S SIGNATURE neva Marshall	

Robert K. Skillman



12.15.63
10:30 am 10:45 P.M.

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 *J S Swalton*

Licensed Embalmer No. *2744*

P. O. Address *J E 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.