

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-025616
STATE FILE NUMBER

FILED JUL 17 1958 Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 3010

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kansas City</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Kansas City</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>N.E. OSTEOPATHIC</u> Length of stay in lb <u>1 year</u>		d. STREET ADDRESS (If outside, give location) <u>450 S. White</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED First Middle Last <u>WILLIAM CHARLES KUGEL</u>			4. DATE OF DEATH Month Day Year <u>6 15 1958</u>
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 11-1888</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bus DRIVER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>PUBLIC TRANS.</u>	11. BIRTHPLACE (City and state or country) <u>Sioux City, Iowa</u>
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A</u>		13a. FATHER'S NAME <u>Unknown</u>	13b. MOTHER'S MAIDEN NAME <u>Unknown</u>
14. NAME OF HUSBAND OR WIFE <u>Emma M. Kugel</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>	16. SOCIAL SECURITY NO. <u>479-09-9173</u>
17. INFORMANT <u>Emma Kugel</u> Address <u>450 S White R. C. Mo</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Ventricular Strain</u> DUE TO (c) <u>atherosclerotic heart disease</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Anasarca</u>	
INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>3 months</u> <u>4200</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 2	
20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <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 Month, Day, Year a.m. p.m.		20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> 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 <u>Nov. 16, 1957</u> to <u>June 14, 1958</u> and last saw ^{her} <u>him</u> alive on <u>June 14, 1958</u> Death occurred at <u>2:35 A.M.</u> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Glenn W. Springer, D. O.</u>		22b. ADDRESS <u>5902 St. John Ave. Kansas City, Mo.</u>	
22c. DATE SIGNED <u>6-16-58</u>		23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	
23b. DATE <u>6/17/1958</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Floyd Cemetery</u>	
23d. LOCATION (City, town, or county) <u>Sioux City, Iowa</u>		23e. (State)	
24. FUNERAL DIRECTOR <u>C. H. Blackman & Son Inc. R. C. Mo</u>		25. DATE RECD. BY LOCAL REG. <u>6-16-58</u>	
26. REGISTRAR'S SIGNATURE <u>Neva Minshall</u>			

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.

Glenn W. Springer USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE MEDICAL CERTIFICATION



201345-8

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 Bert B. Berner

Licensed Embalmer No. 4656
P. O. Address T. C. Mc

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.