

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-033100

STATE FILE NUMBER

4018

FILED SEP 16 1958

Registration District No. 149 Primary Registration District No. 1002

Registrar's No. 4018

S. 300
1-57

Doctor, coronator, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

Raymond W. O'Brien USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE MEDICAL CERTIFICATION

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>ST. Lukes Hosp.</u>		Length of stay in lb. <u>45 years.</u>	d. STREET ADDRESS (If outside, give location) <u>5050 OAK ST.</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>SALLY Winterscheid</u>			4. DATE OF DEATH Month Day Year <u>Aug. 18. 1958</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Cauc.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Mar 1, 1902</u>		9. AGE (In years last birthday) <u>56</u> 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) <u>Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Western Auto</u>	11. BIRTHPLACE (City and state or country) <u>Kansas City Kansas</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>
13a. FATHER'S NAME <u>Peter Winterscheid</u>		13b. MOTHER'S MAIDEN NAME <u>Barbara Marak</u>		14. NAME OF HUSBAND OR WIFE <u>None</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>486-09-8023</u>	17. INFORMANT Address <u>211 E Winthrop</u> <u>Aurelia Fleming (515) K.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>Subarachnoid Haem</u>					INTERVAL BETWEEN ONSET AND DEATH <u>96 hrs</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____					<u>330x</u>
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 <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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 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>8-13-58</u> to <u>8-18-58</u> and last saw her alive on <u>8-18-58</u> Death occurred at <u>9:10</u> p.m. on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>Raymond W O'Brien M.D.</u> (Degree or title)			22b. ADDRESS <u>4620 J.C. Nich. Pkwy K.C. Mo</u>		22c. DATE SIGNED <u>8-20-58</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>Aug 21, 1958</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt Oliver</u>		23d. LOCATION (City, town, or country) (State) <u>Kansas City Mo.</u>
24. FUNERAL DIRECTOR <u>Muehlebach F.H.</u>		ADDRESS <u>6800 Troost</u>		25. DATE RECD. BY LOCAL REG. <u>8-20-58</u>	26. REGISTRAR'S SIGNATURE <u>neva minshall</u>



3:00 - 3:30
4620 J.C.N Phd

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. T. Crowell*

Licensed Embalmer No. *4904*

P. O. Address *J. C. 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.