

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-040035  
STATE FILE NUMBER

FILED DEC 8 1958

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 5457

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>Mo.</b> b. COUNTY <b>Jackson</b>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kansas City</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Kansas City</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>General Hospital</b>		Length of stay in lb <b>3 Weeks 18 yrs.</b>	d. STREET ADDRESS (If outside, give location) <b>2427 McCoy</b>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Nell</b> Middle <b>B.</b> Last <b>Koelmel</b>			4. DATE OF DEATH Month <b>11</b> Day <b>17</b> Year <b>58</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6-2-1897</b>	9. AGE (In years last birthday) <b>61</b>	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laundress</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Gen'l Hospital</b>	11. BIRTHPLACE (City and state or country) <b>Higginsville, Missouri</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>
13a. FATHER'S NAME <b>John Short</b>		13b. MOTHER'S MAIDEN NAME <b>Lillian May Guard</b>		14. NAME OF HUSBAND OR WIFE <b>William Koelmel</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>196-26-0899H</b>	17. INFORMANT Address <b>Mrs. Ruby Miller 1918 Laurel, K.C. Mo.</b>		
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>Aspiration Pneumonia</b>					INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
DUE TO (c) _____					
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 type="checkbox"/> NO <input checked="" type="checkbox"/>		
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 _____ 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 <b>10-21-58</b> to <b>11-17-58</b> and last saw her/him alive on <b>11-17-58</b> Death occurred at <b>6:25 P.M.</b> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <b>Abraham Gelperin</b> (Degree or title) <b>o</b>			22b. ADDRESS <b>K.C. General Hospital</b>		22c. DATE SIGNED <b>11-17-58</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>11-19-1958</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Floral Hills Mem. Gardens</b>		23d. LOCATION (City, town, or county) (State) <b>Kansas City, Mo.</b>
24. FUNERAL DIRECTOR ADDRESS <b>Floral Hills Mem. Chapels, K.C. Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>11-18-58</b>		26. REGISTRAR'S SIGNATURE <b>Neva Marshall</b>	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION  
Abraham Gelperin M.D.

All diseases in Part I must be causally related.

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 *H. J. Mosinger*  
Licensed Embalmer No. *3938*  
P. O. Address *F. C. Me*

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.