

7. Health,
& Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-040315

STATE FILE NUMBER

FILED NOV 18 1958

Registration District No.

146

Primary Registration District No.

3026

Registrar's No.

468

S. 300 4
1-57

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <u>Mo</u> COUNTY <u>Jackson</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Independence</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	CITY OR TOWNSHIP <u>Independence</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULLY NAME OF HOSPITAL OR INSTITUTION <u>5504 Liberty 10 yrs</u>			d. STREET ADDRESS (If outside give location) <u>7005 118th Union</u>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Bertha</u> Middle <u>Wilhelmina</u> Last <u>Gresens</u>			4. DATE OF DEATH Month <u>Oct</u> Day <u>31st</u> Year <u>1958</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</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>Jan. 15-1878</u>	9. AGE (In years (Full birthday)) <u>80</u>	IF UNDER 1 YEAR Months <u>7</u> Days <u>16</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>domestic</u>	11. BIRTHPLACE (City and state or country) <u>Guesebitz, Germany</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13a. FATHER'S NAME <u>Friedrich Gresens</u>		13b. MOTHER'S MAIDEN NAME <u>Wilhelmina Wankke</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.	17. INFORMANT <u>Carol Olsen Ind. Mo</u> Address		
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>Cerebral vascular accident</u>				INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Cerebral arteriosclerosis</u>				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.) <u>331X</u>			
20c. TIME OF INJURY Hour <u>4:10</u> a.m. <u>10-31-58</u> Month, Day, Year 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 <u>7/11/58</u> to <u>10-31-58</u> and last saw her alive on <u>10/28/58</u> Death occurred at <u>4:10</u> p.m. on the date stated above; and to the best of my knowledge, from the causes stated.		22a. SIGNATURE <u>Doris E Link MD</u>		22b. ADDRESS <u>10901 Winner, Independence, Mo.</u>	
22c. DATE SIGNED <u>11-1-58</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>Nov. 3/58</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Wander Grove</u>	
23d. LOCATION (City, town, or county) (State) <u>Independence, Mo</u>					
24. FUNERAL DIRECTOR <u>Voland R. Speaks Ind. Mo</u>		ADDRESS <u>11-2-58</u>		25. DATE RECD. BY LOCAL REG. <u>11-2-58</u>	
				26. REGISTRAR'S SIGNATURE <u>James Craig</u>	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

All diseases in Part I must be causally related.
All diseases in Part I must be causally related. No symptoms will be listed.

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 *Rollie Kessel*

Licensed Embalmer No. *4690*
P. O. Address *Independ. 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.