

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-044161
STATE FILE NUMBER 5697

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

FILED DEC 18 1958

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 Mo</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Kansas City Mo</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>2801 E 78th Ave</u> Length of stay in lb <u>5 1/2 yrs</u>		d. STREET ADDRESS (If outside, give location) <u>2801 E 78th Ave</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Mr John F Herlig</u>			4. DATE OF DEATH Month Day Year <u>12-1-1958</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>4-3-1907</u>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Jeweler</u>		9b. KIND OF BUSINESS OR INDUSTRY <u>Jewelry Store</u>	9c. AGE (In years last birthday) <u>51</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	10c. IF UNDER 1 YEAR Months Days Hours Min. <u>5 1</u>
11. BIRTHPLACE (City and state or country) <u>Kansas City Mo</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Theodore Herlig</u>		13b. MOTHER'S MAIDEN NAME <u>Margaret Walz</u>	
14. NAME OF HUSBAND OR WIFE <u>Mr & Mrs L Herlig</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>496-03-920</u>	
17. INFORMANT <u>Mr & Mrs L Herlig</u>		Address <u>2801 E 78th Ave KC 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>Carcinomatosis</u> DUE TO (c) <u>Carcinoma of Rectum</u>			INTERVAL BETWEEN ONSET AND DEATH <u>0 weeks</u> <u>1 year</u> <u>5 years</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 type="checkbox"/> NO <input checked="" 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 a.m. 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>November 1953</u> , to <u>Present date</u> and last saw her alive on <u>11-20-58</u> Death occurred at <u>11:05 P</u> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>William L Deane MD</u>		22b. ADDRESS <u>1102-130st Grandview Mo</u>	
22c. DATE SIGNED <u>12-2-58</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>12-3-58</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Floral Hills</u>		23d. LOCATION (City, town, or county) (State) <u>Kansas City Mo</u>	
24. FUNERAL DIRECTOR <u>Francis Wornall Funeral Home</u>		25. DATE RECD. BY LOCAL REG. <u>12-2-58</u>	
ADDRESS <u>15-C-MO</u>		26. REGISTRAR'S SIGNATURE <u>Neval Marshall</u>	

All diseases in Part I must be causally related.

MEDICAL CERTIFICATION
William L. Deane: ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

(Licensed Embalmer's Statement on Reverse Side)

NK

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 *Russell N. France*

Licensed Embalmer No. *4255*
P. O. Address *KC 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.