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THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-001371

STATE FILE NUMBER 222

FILED JAN 28 1959 Registration District No. 149 Primary Registration District No. 1002 Registrar's No.

1. PLACE OF DEATH a. COUNTY Jackson b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN KansasCity — Inside Limits Yes [X] No [ ] c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 3608 Wyandotte — Length of stay in Ib 40 yrs.	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Misoouri b. COUNTY Jackson c. CITY OR TOWN Kansas City — Inside Limits Yes [X] No [ ] d. STREET ADDRESS (If outside, give location) 3608 Wyandotte — Reside on Farm Yes [ ] No [X]

3. NAME OF DECEASED (Type or print) First: Dora	Middle: E.	Last: Kalhorn	4. DATE OF DEATH Month 1 Day 11 Year 1959	
5. SEX: Female	6. COLOR OR RACE: White	7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]	8. DATE OF BIRTH: 7-6-1885	9. AGE (In years last birthday): 73 — 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): Homemaker	10b. KIND OF BUSINESS OR INDUSTRY: Home	11. BIRTHPLACE (City and state or country): Dubuque, Iowa	12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME: Michael Cunningham	13b. MOTHER'S MAIDEN NAME: Elizabeth Quinn	14. NAME OF HUSBAND OR WIFE: Henry G. Kalhorn		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) None	16. SOCIAL SECURITY NO. None	17. INFORMANT: Mary M. Collins	Address: 3608 Wyandotte K.C.Mo.	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Pneumonia Bronchial — INTERVAL BETWEEN ONSET AND DEATH 36 hours

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b)

DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): Generalized arteriosclerosis, 5 yrs.

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT [ ] SUICIDE [ ] HOMICIDE [ ]

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. p.m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

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 1950 to Jan 11 1959 and last saw her alive on 12-24-58

Death occurred at 11:30 a.m. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: T Reid Jones (Degree or title) M.D.	22b. ADDRESS: 411 Nichols Road	22c. DATE SIGNED: 1-12-59

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: 1-14-1959	23c. NAME OF CEMETERY OR CREMATORY: Calvary Cemetery	23d. LOCATION (City, town, or county): KansasCity (State): Missouri
24. FUNERAL DIRECTOR: Mellody-McGilley-Eylar	ADDRESS: 20w. Linwood Kc. Mo.	25. DATE RECD. BY LOCAL REG.: 1-13-59	26. REGISTRAR'S SIGNATURE: Neva Minshall

(Licensed Embalmer's Statement on Reverse Side)

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

T. Reid Jones

Dr. T. R. [illegible]
411 [illegible]
VA.1-1350
1-5PM

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 John H. Pryor

Licensed Embalmer No. 2919

P. O. Address [illegible]

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.