Health, Welfare Public Service

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THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-001374
STATE FILE NUMBER

FILED JAN 21 1959 Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 122

1. PLACE OF DEATH
a. COUNTY: Jackson
b. CITY OR TOWN (If outside corporate limits, give TOWNSHIP only): Kansas City — Inside Limits: Yes [X] No [ ]
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location): 4434 Wyoming — Length of stay in 1b: 58 yrs

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri b. COUNTY: Jackson
c. CITY OR TOWN: Kansas City — Inside Limits: Yes [X] No [ ]
d. STREET ADDRESS (If outside, give location): 4434 Wyoming — Reside on Farm: Yes [ ] No [X]

3. NAME OF DECEASED (Type or print): First: KATHERINE Middle: Last: KERSTING

4. DATE OF DEATH: Month 1 Day 8 Year 59

5. SEX: Fe

6. COLOR OR RACE: Wh

7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]

8. DATE OF BIRTH: 8-24-1866

9. AGE (In years last birthday): 92 — 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): At Home
10b. KIND OF BUSINESS OR INDUSTRY: XX
11. BIRTHPLACE (City and state or country): Austria
12. CITIZEN OF WHAT COUNTRY?: USA

13a. FATHER'S NAME: Joseph Nick
13b. MOTHER'S MAIDEN NAME: No Record
14. NAME OF HUSBAND OR WIFE: John Kersting

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): XX
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Joseph F. Kersting, Address: 4434 Wyoming

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cirrhosis of Liver — INTERVAL BETWEEN ONSET AND DEATH: 2 yrs.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): Senility — yrs.
DUE TO (c):
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): 5

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

MEDICAL CERTIFICATION

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 1916, to 1-8-59 and last saw her/him alive on 1-8-59. Death occurred at 5:45 A.M. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: John O. Skinner (Degree or title): MD
22b. ADDRESS: 1402 Bryant Bldg.
22c. DATE SIGNED: 1-8-59

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal
23b. DATE: 1-10-59
23c. NAME OF CEMETERY OR CREMATORY: Mt. Calvary Cemetery
23d. LOCATION (City, town, or county): Kansas City (State): Kansas

24. FUNERAL DIRECTOR: Wagner Funeral Home, K C Mo — ADDRESS
25. DATE RECD. BY LOCAL REG.: 1-8-59
26. REGISTRAR'S SIGNATURE: Treva 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

John O. Skinner

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 Alvin R. Hauenschild

Licensed Embalmer No. 4159

P. O. Address K. 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.