

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-001408

STATE FILE NUMBER

228

JAN 28 1959

Registration District No. 149 Primary Registration District No. 1002

Registration No. 228

300
1-57

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|--|----------------------------------|---|--|---|---|
| 1. PLACE OF DEATH a. COUNTY Jackson | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Jackson | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) TOWN Kansas City | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | c. CITY OR TOWN Kansas City | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 611 E. 54th Street | | Length of stay in lb 45 years | d. STREET ADDRESS (If outside, give location) 611 E. 54th Street | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First Middle Last MRS. ROSE J. LUNDTEIGEN | | | 4. DATE OF DEATH Month Day Year January 12, 1959 | | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Feb. 21, 1869 | 9. AGE (In years last birthday) 89 | IF UNDER 1 YEAR Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY At Home | 11. BIRTHPLACE (City and state or country) Medinas, New York | | 12. CITIZEN OF WHAT COUNTRY? USA |
| 13a. FATHER'S NAME James Ryan | | 13b. MOTHER'S MAIDEN NAME Viona Hottzinger | | 14. NAME OF HUSBAND OR WIFE Andrew Lundteigen | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. None | 17. INFORMANT Address Andrew Lundteigen, Jr. - 5225 Rhinehart Drive Roeland, Park | | |

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|---|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Generalized arteriosclerosis - secondary</i> | | INTERVAL BETWEEN ONSET AND DEATH 3 yrs. |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <i>cerebral degeneration, malnutrition & anemia</i> DUE TO (c) <i>Essential hypertension - chronic renal arteriosclerosis</i> | | |
| 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 <i>April 15, 1943</i> to <i>January 12, 1959</i> and last saw her ^{her} alive on <i>Jan 9, 1959</i> Death occurred at <i>3:15 am</i> on the date stated above; and to the best of my knowledge, from the causes stated. | | | | | |
| 22a. SIGNATURE (Degree or title) <i>Joseph Embelmer MD</i> | | | 22b. ADDRESS <i>838 Prof Rd. Kansas City 6 Mo</i> | | 22c. DATE SIGNED <i>1-12-59</i> |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation | | 23b. DATE 1-13/59 | 23c. NAME OF CEMETERY OR CREMATORY D. W. Newcomer's Sons | | 23d. LOCATION (City, town, or county) (State) Kansas City, Missouri |
| 24. FUNERAL DIRECTOR ADDRESS Stine & McClure Und. Co., K.C., Missouri | | | 25. DATE RECD. BY LOCAL REG. 1-13-59 | 26. REGISTRAR'S SIGNATURE <i>new Marshall</i> | |

All diseases in Part I must be causally related.
 USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
 MEDICAL CERTIFICATION
 Joseph E. Walker

8-11-1918

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 *William M. Turner*

Licensed Embalmer No. *4648*
P. O. Address *..... City,*

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.