ealth,
Welfare
ublic
ervice

300
-57

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-005526
STATE FILE NUMBER 555

FILED FEB 19 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 Kansas City — Inside Limits Yes [X] No [ ]
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) Kelly Nursing Home — Length of stay in 1b 61 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) 6250 E 11 st — Reside on Farm Yes [ ] No [X]

3. NAME OF DECEASED (Type or print) First JOHN Middle Last EGNER
4. DATE OF DEATH Month January Day 27 Year 1959
5. SEX Male
6. COLOR OR RACE White
7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH Aug 16 1876
9. AGE (In years last birthday) 82 — 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) Retired
10b. KIND OF BUSINESS OR INDUSTRY Butler Mfg Co
11. BIRTHPLACE (City and state or country) Germany
12. CITIZEN OF WHAT COUNTRY? USA
13a. FATHER'S NAME Mathias Egner
13b. MOTHER'S MAIDEN NAME Barbara Rossman
14. NAME OF HUSBAND OR WIFE Emma Egner
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 487-01-9923
17. INFORMANT Mrs Emma Egner Address 6250 E 11th St 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) Cerebral hemorrhage — INTERVAL BETWEEN ONSET AND DEATH 4-5 days
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) 22/X
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 1-27-59, to 1-27-59 and last saw her/him alive on 1-27-59
Death occurred at m on the date stated above; and to the best of my knowledge, from the causes stated.
22a. SIGNATURE L. E. Riller (Degree or title) M.D.
22b. ADDRESS K. C. Mo.
22c. DATE SIGNED 1-29-59
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE 1/30/59
23c. NAME OF CEMETERY OR CREMATORY Floral Hills Cemetery
23d. LOCATION (City, town, or county) (State) Kansas City Missouri
24. FUNERAL DIRECTOR ADDRESS Sheil Funeral Home Kansas City Mo
25. DATE RECD. BY LOCAL REG. 1-29-59
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

L. E. Riller

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 Thomas A. Shil

Licensed Embalmer No. 4954

P. O. Address K.C.M.

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.