

Health,  
Welfare  
Public  
Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-009425

STATE FILE NUMBER

FILED MAR 26 1959

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 1332

300  
-57

1. PLACE OF DEATH a. COUNTY <b>JACKSON</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY <b>JACKSON</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>KANSAS CITY</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>KANSAS CITY</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>MENORAH MEDICAL CENTER 3 YEARS</b>		Length of stay in lb	d. STREET ADDRESS (If outside, give location) <b>4521 VIRGINIA AVENUE</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>WILLIAM</b> Middle <b>J.</b> Last <b>GUDENKAUF</b>			4. DATE OF DEATH Month <b>MARCH</b> Day <b>12</b> Year <b>1959</b>		
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5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>FEBRUARY 11, 1892</b>	9. AGE (In years last birthday) <b>67</b>	IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	IF UNDER 24 HRS. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED- BUTCHER</b>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>SENECA, KANSAS</b>	12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>
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13a. FATHER'S NAME <b>CLEMENT H. GUDENKAUF</b>	13b. MOTHER'S MAIDEN NAME <b>MARY STUCKHOFF</b>	14. NAME OF HUSBAND OR WIFE <b>MRS. CORA GUDENKAUF</b>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>	16. SOCIAL SECURITY NO. <b>513-03-0564</b>	17. INFORMANT <b>MRS. CORA GUDENKAUF</b>	<b>4521 VIRGINIA AVENUE KANSAS CITY MISSOURI</b>
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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) <u>Cerebral Hemorrhage</u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 hrs</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Hypertension</u>		
DUE TO (c) _____		?
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 checked="" type="checkbox"/> NO <input 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.) <u>331</u>
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20c. TIME OF INJURY Hour _____ Month _____ Day _____ Year _____ a.m. _____ p.m. _____
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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 <b>SENECA</b>	COUNTY <b>KANSAS</b>	STATE
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21. I attended the deceased from <u>3-11-59</u> to <u>3-12-59</u> and last saw <sup>from</sup> him alive on <u>3-11-59</u> Death occurred at <u>1:05 A.</u> <u>3-12-59</u> m on the date stated above; and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE <u>J. S. Hoffinan MD</u>	(Degree or title)	22b. ADDRESS <u>751 E 63rd St KCMO</u>	22c. DATE SIGNED <u>3-12-59</u>
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23a. BURIAL, CREMATION, OR REMOVAL (Specify) <b>BURIAL</b>	23b. DATE <b>MARCH 12, 1959</b>	23c. NAME OF CEMETERY OR CREMATOR <b>ST. PETER'S CEMETERY</b>	23d. LOCATION (City, town, or county) (State) <b>SENECA KANSAS</b>
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24. FUNERAL DIRECTOR <b>D. W. NEWCOMER'S SONS KANSAS CITY, MO.</b>	<b>1501 BRUSH CREEK BLVD.</b>	RECD. BY LOCAL REG. <u>3-12-59</u>	26. REGISTRAR'S SIGNATURE <u>Neve Marshall</u>
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(Licensed Embalmer's Statement on Reverse Side)

J. S. Hoffinan  
MEDICAL CERTIFICATION  
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
All diseases in Part I must be causally related.

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 .... *Bernard L. Moran*

Licensed Embalmer No. *4250*

P. O. Address *MD 110*

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.