

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-009471  
STATE FILE NUMBER

FILED MAR 26 1959

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 1250

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u>									
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kansas City</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Kansas City</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>							
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Trinity Lutheran</u>			Length of stay in 1b <u>72 years.</u>		d. STREET ADDRESS <u>719 W. 38<sup>th</sup> ST.</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First <u>Delaney M</u> Middle <u>Hutchens</u> Last				4. DATE OF DEATH Month <u>MARCH</u> Day <u>7</u> Year <u>1959</u>									
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Cauc.</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>MARCH 26, 1882</u>		9. AGE (In years last birthday) <u>76</u>		10. UNDER 1 YEAR Months Days Hours Min.		11. UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Medical Doctor</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Physician</u>		11. BIRTHPLACE (City and state or country) <u>ARCADIA ILLINOIS</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				
13a. FATHER'S NAME <u>UNKNOWN</u>				13b. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>				14. NAME OF HUSBAND OR WIFE <u>MRS. EDNA HUTCHENS</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>				16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT Address <u>Edna Hutchens 719 W. 38<sup>th</sup> ST.</u>							
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>Bronchial Pneumonia</u>										INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>			
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Generalized Peritonitis</u>										<u>4 days</u>			
DUE TO (c) <u>Diverticulitis of Bladder</u>										<u>?</u>			
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? 1 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.)										
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 <u>2-21-59</u> to <u>3-7-59</u> and last saw him alive on <u>3-6-59</u> Death occurred at <u>5:00 A.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE <u>Carl H. Reitz M.D.</u> (Degree or title)						22b. ADDRESS <u>404 1/2 W. 75<sup>th</sup></u>			22c. DATE SIGNED <u>3-9-59</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <u>March 9, 1959</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Forest Hill Cemetery</u>				23d. LOCATION (City, town, or county) (State) <u>Kansas City, Missouri</u>					
24. FUNERAL DIRECTOR <u>Muehlebach</u> ADDRESS <u>6800 Troost</u>				25. DATE RECD. BY LOCAL REG. <u>3-9-59</u>		26. REGISTRAR'S SIGNATURE <u>Reva Marshall</u>							

(Licensed Embalmer's Statement on Reverse Side)

Health, Welfare, Public Service

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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

Carl H. Reitz

AL 4-30-6  
4:42 W95.8 20

82  
Trinity Lutheran Hospital

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 *R. Nichols* .....

Licensed Embalmer No. 4997 .....

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.