

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-009593
STATE FILE NUMBER 1141

FILED MAR 19 1959

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 1141

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) 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 St. Mary's Hospital		Length of stay in lb 88 yrs	d. STREET ADDRESS (If outside, give location) 4609 Bell		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last MRS. MARY S. OETKEN			4. DATE OF DEATH Month Day Year March 1 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 Aug 18, 1871	9. AGE (In years last birthday) 88-87	IF UNDER 1 YEAR Months Days 8 7
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (City and state or country) Kansas City, Mo.		12. CITIZEN OF WHAT COUNTRY? U. S. A.
13a. FATHER'S NAME Henry W. Spanger		13b. MOTHER'S MAIDEN NAME Katherine Ann Khun		14. NAME OF HUSBAND OR WIFE August Oetken	
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 Mrs. Ruby Rogers, 4609 Bell		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Culmonary edema					INTERVAL BETWEEN ONSET AND DEATH 2 hrs
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) Hypertensive Cardiac disease.					
DUE TO (c) 443X					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Cerebral vascular occlusion					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 a.m. p.m. Month, Day, Year					
20d. INJURY OCCURRED WHILE AT WORK <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 2-28-59 to March 1, 59 and last saw her alive on Mar 1, 1959 Death occurred at 10 P m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Doctor or title) John R. Whiteman MD			22b. ADDRESS 6314 Brookside Pl		22c. DATE SIGNED 3-2-59
23a. BURIAL, CREMATION, REBURYAL (Specify)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)
Burial		3-4-1959	Forest Hill Cemetery		Kansas City, Mo.
24. FUNERAL DIRECTOR ADDRESS Mellody-McGilley-Eylar Funeral Home Woodland-Linwood			25. DATE RECD. BY LOCAL REG. 3-2-59	26. REGISTRAR'S SIGNATURE Neva Marshall	

MEDICAL CERTIFICATION
John R. Whiteman USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
All diseases in Part I must be causally related.



W. John R. ...
6314 Brookside
Hi 4-660

2-5 PM

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 *George A Jackson*

Licensed Embalmer No. *5059*
P. O. Address *A C M O*

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.