

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-013338

FILED MAY 13 1959

Registration District No. 149

Primary Registration District No. 1002

STATE FILE NUMBER
Registrar's No. 2036

300
-57

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before a. STATE Mo. b. COUNTY Jackson	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City		c. CITY OR TOWN Kansas City	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Hyde Park Nursing Home		d. STREET ADDRESS (If outside, give location) 2620 E. 69th St.	
3. NAME OF DECEASED (Type or print) First ANGELINE Middle B. Last HENNIG		4. DATE OF DEATH: Month April Dpy 22 Year 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> 2. DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 29, 1875
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY home	11. BIRTHPLACE (City and state or country) Coleta, Ill. 1
13a. FATHER'S NAME William Colcord		13b. MOTHER'S MAIDEN NAME Mary Fraser	14. NAME OF HUSBAND OR WIFE William Hennig
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 Robert Riggs 2620 E. 69th St.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Advanced encephalomalacia & Senility			INTERVAL BETWEEN ONSET AND DEATH 5-10 Years.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Cerebral Arteriosclerosis			" "
DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 332X			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 March 1958 to 22 April 59 and last saw ^{her} _{him} alive on: 12 April 1959 Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Philip G. Kaul M.D.		22b. ADDRESS Plaza Time Bldg - K.C., Mo.	22c. DATE SIGNED 4-25-59
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 4-24-59	23c. NAME OF CEMETERY OR CREMATORY Forest Hill Cemetery	23d. LOCATION (City, town, or county) (State) Kansas City, Mo.
24. FUNERAL DIRECTOR ADDRESS Melody-McGilley-Eylar 1800 Linwood		25. DATE RECD. BY LOCAL REG. 4-23-59	26. REGISTRAR'S SIGNATURE Neve Miniball

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

Philip G. Kaul

*Dr. Phillips Kneel
Pharm Technol. F.B.E.T.
K. 1226
1-5 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 *Melvin Barteaux*

Licensed Embalmer No. *4903*
P. O. Address *Kc 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.