

JURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-020462

FILED JUL 13 1959

042 Primary Registration District No. 1000 Registrar's No. 704

STATE FILE NUMBER

UNRECORDED

1. PLACE OF DEATH a. COUNTY Buchanan		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Buchanan	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Joseph		Length of stay in 1b 76 years	c. CITY OR TOWN St. Joseph Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 2009 Olive Street		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS 2009 Olive Street (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) Gesina First Inselmann Middle July 6, 1959 Last Inselsmann	4. DATE OF DEATH Month July Day 6 Year 1959
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5. SEX Female	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH Jan. 11, 1874	9. AGE (last birthday) 85	IF UNDER 1 YEAR Months 4 Days 0 Hours 0 Min. 0	IF UNDER 24 HR Hours 0 Min. 0
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Germany	12. CITIZEN OF WHAT COUNTRY USA
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13a. FATHER'S NAME Casper Inselmann	13b. MOTHER'S MAIDEN NAME Maria Grotheer	14. NAME OF HUSBAND OR WIFE
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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) No	16. SOCIAL SECURITY NO. none	17. INFORMANT Maria Inselmann Address St. Joseph, Missouri.
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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) Cerebral Vascular Thrombosis	INTERVAL BETWEEN ONSET AND DEATH 4 months
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Cerebral Arteriosclerosis	6 years
DUE TO (c) Arteriosclerosis	unknown

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)	PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown
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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.)
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20c. TIME OF INJURY Hour 4:20 P. Month, Day, Year 4/23/53	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 St. Joseph, Missouri COUNTY Missouri STATE Missouri
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21. I attended the deceased from 4/23/53 to 7/6/59 and last saw her/him alive on 7/6/59 Death occurred at 4:20 P. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Sharon E. Wagoner M.D.	22b. ADDRESS 301 Illinois Ave St. Joseph, Missouri	22c. DATE SIGNED 7/8/59 (State)
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23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE July 8, 1959	23c. NAME OF CEMETERY OR CREMATORY Ashland Cemetery	23d. LOCATION (City, town, or county) St. Joseph, Missouri.
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24. FUNERAL DIRECTOR Meierhoffer & Fleeman ADDRESS St. Joseph, Mo.	25. DATE RECD. BY LOCAL REG. July 9, 1959	26. REGISTRAR'S SIGNATURE Mrs. Clark Stoddell
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(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

BY AFFIDAVIT OF S.E. Wagoner, M.D. MEDICAL CERTIFICATION

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

Albert C. Harrington

Licensed Embalmer No. *3258*

P. O. Address *H. Campbell*

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.