

Health, Welfare, Public Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-021362
STATE FILE NUMBER

FILED JUN 17 1959

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 2624

300
-57
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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) OR TOWN Kansas City		c. CITY OR TOWN Kansas City	
c. FULL NAME OF (If NOT in Hospital, give location) HOSPITAL OR INSTITUTION Menorah Medical Center		Length of stay in 1b 3 1/2 YRS.	
3. NAME OF DECEASED (Type or print) First Middle Last Peter JACOB Ganns		4. DATE OF DEATH Month Day Year 5 25 1959	
5. SEX Male	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 4-11-79
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) MUENSTER, GERMANY
13a. FATHER'S NAME JACOB GANNS		13b. MOTHER'S MAIDEN NAME KATHERINA PREPPER	14. NAME OF HUSBAND OR WIFE EMMY GANNS
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 WERNER GANNS 5531 INDIANA AVE, K. C. MO.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Obstruction of trachea Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) Carcinoma of Larynx & Trachea DUE TO (c) 2 years.			INTERVAL BETWEEN ONSET AND DEATH 1992
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 10-12-58 to 11-12-58 and last saw her/him alive on 11-12-58 Death occurred at 5:45 PM - 5-25-59 on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Norman A. Ginsberg M.D.		22b. ADDRESS 757 East 63rd K.C.Mo.	
22c. DATE SIGNED 5-27-59			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE MAY 27, 1959	
23c. NAME OF CEMETERY OR CREMATORY MEMORIAL PARK CEM		23d. LOCATION (City, town, or county) (State) KANSAS CITY, MO.	
24. FUNERAL DIRECTOR ADDRESS DW Newcome's Sons, H.C. Mo.		25. DATE RECD. BY LOCAL REG. 5-27-59	
		26. REGISTRAR'S SIGNATURE Beva Minshall	

All diseases in Part I must be causally related.

Norman A. Ginsberg
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Em 3, 2322

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 L. Savage*

Licensed Embalmer No. *4812*

P. O. Address *Kansas City*

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.