

alth,  
elfare  
blic  
ervice

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-021815

FILED JUL 7 1959

Registration District No. 146 Primary Registration District No. 3026 STATE FILE NUMBER 297 Registrar's No. 297

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Jackson</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Independence</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Independence</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>505 N. Kiger</b>		Length of stay in 1b <b>32 yrs.</b>	700 <sup>d</sup> STREET ADDRESS (If outside, give location) <b>505 N. Kiger</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>JOSEPH</b> Middle <b>FRANK</b> Last <b>DREISBACH</b>			4. DATE OF DEATH Month <b>June</b> Day <b>25</b> Year <b>1959</b>	
--	--	--	--	--

5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 9, 1874</b>	9. AGE (In years last birthday) <b>85</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Hours Min.
-----------------------	----------------------------------	---	--	--	---	-------------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired salesman-school supplies</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>Germany</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
--	--	-----------------------------------	--	--

13a. FATHER'S NAME <b>Unknown</b>	13b. MOTHER'S MAIDEN NAME <b>Unknown</b>	14. NAME OF HUSBAND OR WIFE <b>Lydia Bell Dreisbach, dec.</b>
--------------------------------------	---	--

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	16. SOCIAL SECURITY NO. <b>199-14-4699</b>	17. INFORMANT <b>Mrs. Sadie Fisher, Indep., Mo.</b>	Address
---	---	--	---------

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypertension and infection left kidney</b>		INTERVAL BETWEEN ONSET AND DEATH <b>15 hrs.</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>Carcinoma of the prostate</b>	<b>2 yrs</b>
	DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Advanced Chronic Bronchitis</b>		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.	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 <b>May 21, 1958</b> to <b>June 27, 1959</b> and last saw him alive on <b>June 24, 1959</b> Death occurred at <b>1115 Olive</b> m in the date stated above; and to the best of my knowledge, from the causes stated.
---

22a. SIGNATURE (Degree or title) <b>W. H. Hecker</b>	22b. ADDRESS <b>604 W. Maple Independence, Mo.</b>	22c. DATE SIGNED <b>6/26/59</b>
---	---	------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>June 29, 1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mount Moriah Cem.</b>	23d. LOCATION (City, town, or county) (State) <b>Kansas City, Mo.</b>
--	-----------------------------------	--	--

24. FUNERAL DIRECTOR <b>OTT &amp; MITCHELL, Indep., Mo.</b>	25. DATE RECD. BY LOCAL REG. <b>6-29-59</b>	26. REGISTRAR'S SIGNATURE <b>James L. [Signature]</b>
--	--	--

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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 Jason White .....  
Licensed Embalmer No. 4955 .....  
P. O. Address Indep .....

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.