

IRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-025468

JUL 17 1959

149

1002

3276

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Ks. b. COUNTY Johnson	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City		Length of stay in lb 6 DAYS	c. CITY OR TOWN Prairie Village Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Research Hospital		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 6833 El Monte Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First HELEN Middle STEWART Last THIELEN			4. DATE OF DEATH Month July Day 5 Year 1959			
5. SEX Female	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH May 4 1893	9. AGE (last birthday) 66	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during life, even if retired) Part Owner		10b. KIND OF BUSINESS OR INDUSTRY American Excelsior Company		11. BIRTHPLACE (City and state or country) Marion Ohio		12. CITIZEN OF WHAT COUNTRY USA

13a. FATHER'S NAME Jarry Darmandy		13b. MOTHER'S MAIDEN NAME Maggie		14. NAME OF HUSBAND OR WIFE Edgar N. Thielen	
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. 493-32-4313A		17. INFORMANT Address Edgar N. Thielen 6833 El Monte	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure		INTERVAL BETWEEN ONSET AND DEATH 3 hrs years
DUE TO (b) Coronary Artery Disease		
DUE TO (c) _____		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Severe anemia		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

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 Kansas City, Jackson, Mo
21. I attended the deceased from 6/28/59 to 7/5/59 and last saw him alive on 7/4/59 Death occurred at 3:30 AM m on the date stated above, and to the best of my knowledge, from the causes stated.		

22a. SIGNATURE (Deceased or title) G.R. Reinhardt MD	22b. ADDRESS 1332 Prof. Bldg	22c. DATE SIGNED 7/5/59
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 7-5-59	23c. NAME OF CEMETERY OR CREMATORY _____
23d. LOCATION (City, town, or county) (State) Oshkosh Wisconsin		

24. FUNERAL DIRECTOR ADDRESS Stine & McClure K. C. Mo.	25. DATE RECD. BY LOCAL REG. 7-5-59	26. REGISTRAR'S SIGNATURE Neva Marshall
--	---	---

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF G. R. Reinhardt

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Joe B. Yoder

Licensed Embalmer No. 4173

P. O. Address K. C. W.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.