

**DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**59-025503**

**FILED VS AUG 14 1959**

Registration District No. 949 Primary Registration District No. 1002 Registrar's No. 3697 STATE FILE NUMBER

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>Kansas City</b>		Length of stay in 1b <b>38 years</b>	c. CITY OR TOWN <b>Kansas City</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>K.C. Convalescent Home</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>813 Archibald St.</b>		
3. NAME OF DECEASED (Type or print) First <b>LAURA</b> Middle <b>WESTPHAL</b> Last <b>WESTPHAL</b>			4. DATE OF DEATH Month <b>July</b> Day <b>29</b> Year <b>1959</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>10-23-1894</b>	9. AGE (last birthday) <b>64</b>	IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housekeeper</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>Corning, Kansas</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13a. FATHER'S NAME <b>Wm. Westphal</b>		13b. MOTHER'S MAIDEN NAME <b>Unknown</b>		14. NAME OF HUSBAND OR WIFE <b>----</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>488-36-0123</b>	17. INFORMANT Address <b>Agusta Westphal 813 Archibald K.C.Mo.</b>			
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>Cerebral Hemorrhage</b>					INTERVAL BETWEEN ONSET AND DEATH <b>Four Hours</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Cerebral Arteriosclerosis</b>					<b>Unknown</b>	
DUE TO (c) <b>Essential Hypertension</b>					<b>Unknown</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Senile Dementia Arteriosclerosis</b>				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		
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input 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 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	
21. I attended the deceased from <b>6-26-59</b> to <b>7-24-59</b> and last saw her/him alive on <b>7-29-59</b> 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) <b>M.F. Sewell M.D.</b>			22b. ADDRESS <b>1722 W 39</b>		22c. DATE SIGNED <b>7-30-59</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>8-1-59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Forest Hill</b>	23d. LOCATION (City, town, or county) (State) <b>Kansas City, Missouri</b>			
24. FUNERAL DIRECTOR ADDRESS <b>Freeman Mortuary Kansas City, Missouri</b>		25. DATE RECD. BY LOCAL REG. <b>7-30-59</b>	26. REGISTRAR'S SIGNATURE <b>Neva Minshall</b>			

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF M.F. Sewell

**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



Licensed Embalmer No. 4793

P. O. Address K. C., 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.