DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

59–029227
STATE FILE NUMBER

FILED VS AUG 21 1959

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 3791

1. PLACE OF DEATH
a. COUNTY: JACKSON
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: KANSAS CITY — Length of stay in 1b: 73 YRS
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: 723 FULLER — Inside Limits: Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MISSOURI b. COUNTY: JACKSON
c. CITY OR TOWN: KANSAS CITY — Inside Limits: Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location): 723 FULLER — Reside on Farm: Yes ☐ No ☒

3. NAME OF DECEASED (Type or print) First: EDNA Middle: Last: MUNKERS
4. DATE OF DEATH Month, Day, Year: AUGUST 3, 1959
5. SEX: FEMALE
6. COLOR OR RACE: CAUC.
7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐
8. DATE OF BIRTH: APR 29 1886
9. AGE (last birthday): 73 — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HR: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE
10b. KIND OF BUSINESS OR INDUSTRY: HOME
11. BIRTHPLACE (City and state or country): KANSAS CITY, MO.
12. CITIZEN OF WHAT COUNTRY: U.S.A.
13a. FATHER'S NAME: NILS SEMSTEAD
13b. MOTHER'S MAIDEN NAME: RACHEL OLSON
14. NAME OF HUSBAND ~~OR WIFE~~: MORTON MUNKERS
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service): NO
16. SOCIAL SECURITY NO.: NONE
17. INFORMANT: MORTON MUNKERS Address: 723 FULLER

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Mesenteric Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 2 days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): Generalized Arteriosclerosis — Unknown
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): + Hypertensive Cardiovascular disease
Arteriosclerotic gangrene left leg.

PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☒ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
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 ☐ NOT WHILE AT WORK ☐
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 8/2/59 to 8/2/59 and last saw her alive on 8/2/59
Death occurred at 8/3/59 7 AM on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: Jerome Earl Van Buskirk (Degree or title): M.D.
22b. ADDRESS: 5246 St. John KCMo
22c. DATE SIGNED: 8/4/59

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE: Aug 5, 1959
23c. NAME OF CEMETERY OR CREMATORY: MT. WASHINGTON
23d. LOCATION (City, town, or county): KANSAS CITY (State): MO.

24. FUNERAL DIRECTOR: MUEHLEBACH ADDRESS: 6800 TROOST
25. DATE RECD. BY LOCAL REG.: 8-5-59
26. REGISTRAR'S SIGNATURE: Neva Minshall

(Licensed Embalmer's Statement on Reverse Side)

BY AFFIDAVIT OF Terrance Earl Van Buskirk MEDICAL CERTIFICATION

DOCUMENT

Dr. KIENBERGER
5346 ST. John
BE 1-0141
1:30 — 4:30. Tues.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____ Signed R E Wichel
Signature of Student Embalmer

Licensed Embalmer No. 499

P. O. Address K.C.

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