

DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-029376

FILED VS SEP 4 1959 149

Registration District No. **1002** Primary Registration District No. **1002**

Registrar's No. **4020**

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY Jackson	
b. CITY (If outside corporate limits, give TOWNSHIP only) Kansas City		c. CITY OR TOWN Kansas City	
Length of stay in 1b 22 yrs		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		d. STREET ADDRESS (If outside, give location) 4039 Charlotte	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First HELEN Middle EVELYN Last WIEDMAN			4. DATE OF DEATH Month 8 Day 17 Year 59			
5. SEX Fe	6. COLOR OR RACE Wh	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 7-21-06	9. AGE (last birthday) 53	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) Bookkeeper		10b. KIND OF BUSINESS OR INDUSTRY Mch'y & Supply		11. BIRTHPLACE (City and state or country) Chicago, Illinois		12. CITIZEN OF WHAT COUNTRY USA
13a. FATHER'S NAME John A. Wiedman		13b. MOTHER'S MAIDEN NAME Minnie A. Waiss		14. NAME OF HUSBAND OR WIFE XX		
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. 149-18-1480		17. INFORMANT Address Miss Hedwig Wiedman, 4039 Charlotte		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Generalized Abdominal Carcinomatosis</i>		INTERVAL BETWEEN ONSET AND DEATH 6 months
DUE TO (b) <i>Adeno carcinoma - sigmoid colon</i>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. <i>Resection of colon and metastatic mesenteric lymph glands</i>		1 year <i>Dec 16, 1958</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		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 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 _____

21. I attended the deceased from <i>Dec 14, 1939</i> to <i>Aug 17, 1959</i> and last saw her alive on <i>Aug 16, 1959</i> Death occurred at <i>2:10 A.M.</i> on the date stated above, and to the best of my knowledge, from the causes stated.			
22. SIGNATURE (Degree or title) <i>Carl R. Ferris M.D.</i>	22b. ADDRESS <i>535 Argyle Bldg Kansas City Mo</i>	22c. DATE SIGNED <i>Aug 17, 1959</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 8-19-1959	23c. NAME OF CEMETERY OR CREMATORY Forest Hill	23d. LOCATION (City, town, or county) (State) Kansas City Mo.
24. FUNERAL DIRECTOR ADDRESS <i>Wagner Funeral Home, N. C. Mo</i>		25. DATE RECD. BY LOCAL REG. 8-18-59	26. REGISTRAR'S SIGNATURE <i>Irene Minshall</i>

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF **Carl R. Ferris**

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 Alvin R. Howard

Licensed Embalmer No. 4157

P. O. Address K. C. 7th

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.