

FURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-036198

FILED VS NOV 2 1959

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 5041 STATE FILE NUMBER

ENDED

1. PLACE OF DEATH a. COUNTY <u>JACKSON</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>JACKSON</u>				
b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN <u>KANSAS CITY</u>		Length of stay in 1b <u>74yrs.</u>		c. CITY OR TOWN <u>KANSAS CITY</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>616 WEST 39th TERR</u>			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (if outside, give location) <u>616 WEST 39th TERR</u>			Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>CHALRES Louis</u>			First	Middle <u>HAHN</u>		Last	4. DATE OF DEATH Month <u>OCT</u> Day <u>18</u> , Year <u>1959</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>JULY 6, 1885</u>	9. AGE (last birthday) <u>74 yrs.</u>	IF UNDER 1 YEAR Months Days Hours	IF UNDER 24 HR Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>building contractor</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>KANSAS CITY MO.</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>LOUIS HAHN</u>			13b. MOTHER'S MAIDEN NAME <u>Exilda REAVIS</u>			14. NAME OF HUSBAND OR WIFE <u>MAUDE HAHN</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. <u>496 10 2634</u>		17. INFORMANT Address <u>MAUDE HAHN 616 WEST 39th TERRACE</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Rupture of abdominal Aortic Aneurysm 15 min.</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Aortic (abdominal) aneurysm 6 mos.</u> DUE TO (c) <u>General Arteriosclerosis & Hypertension 7 Years+</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Arteriosclerotic Heart Disease</u> 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 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 <u>May 1952</u> to <u>18 Oct. 1959</u> and last saw ^{her} <u>him</u> alive on <u>Sept. 5, 1959</u> Death occurred at <u>11:55</u> <u>A.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) <u>Philip G. Raul MD.</u>				22b. ADDRESS <u>711 Nichols Rd.</u>			22c. DATE SIGNED <u>18 Oct. 59</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>10/21/1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Calvary Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Kansas City Missouri</u>			
24. FUNERAL DIRECTOR ADDRESS <u>D.W. Newcomers Sons 1331 Brush Creek Blvd.</u>				25. DATE RECD. BY LOCAL REG. <u>10-20-59</u>		26. REGISTRAR'S SIGNATURE <u>Irva Marshall</u>		
Kansas City Missouri								

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

Philip G. Raul

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 Chester K. Proctor

Licensed Embalmer No. 492

P. O. Address KP Mc

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.