

URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS DEC 7 1959

59-039880

STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 5589

1. PLACE OF DEATH a. COUNTY Jackson				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY JACKSON					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City		Length of 19 ¹⁴ in days ^{years} 3		c. CITY OR TOWN RAYTOWN		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Marys Hospital			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 10408 EAST 59th STREET		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Mary Middle Catherine Last Ahlstrom				4. DATE OF DEATH Month November Day 18 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 April 23 1933	9. AGE (last birthday) 26	IF UNDER 1 YEAR Months	IF UNDER 24 HR Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SENIOR CLERK			10b. KIND OF BUSINESS OR INDUSTRY PRUDENTIAL		11. BIRTHPLACE (City and state or country) CHEROKEE, KANSAS.		12. CITIZEN OF WHAT COUNTRY USA		
13a. FATHER'S NAME John E. Colyer			13b. MOTHER'S MAIDEN NAME ETHEL BOLICK			14. NAME OF HUSBAND OR WIFE ROBERT T. AHLSTROM			
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. 497 34 3947		17. INFORMANT Address ROBERT T. AHLSTROM 10408 E. 59th ST.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CHRONIC NEPHRITIS WITH UREMIA & ANASARCA 5 MOS.								INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b)		DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) HYPOLASTIC RIGHT KIDNEY, NON FUNCTIONING.						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 checked="" 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 JUN 27, 1959 to NOV 18, 1959 and last saw her alive on Nov. 17, 1959 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) James W. Fowler, M.D.				22b. ADDRESS 1103 GRAND AVE. KANSAS CITY, MO.				22c. DATE SIGNED 11-18-59	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE NOV 21, 1959	23c. NAME OF CEMETERY OR CREMATORY MEMORIAL PARK CEM		23d. LOCATION (City, town, or county) (State) KANSAS CITY MO.				
24. FORMAL DIRECTOR ADDRESS D. W. NEWCOMER'S SONS K. C. MO.				25. DATE RECD. BY LOCAL REG. 11-20-59		26. REGISTRAR'S SIGNATURE Neva Marshall			

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF JAMES W. FOWLER

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 *W. Nelson*

Licensed Embalmer No. 4421

P. O. Address Kaneohe

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