

URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-039921

FILED VS NOV 30 1959

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 5505 STATE FILE NUMBER

UNDECEASED

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 stay in 1b 21 Yrs		c. CITY OR TOWN Kansas City		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 4739 Charlotte			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 4739 Charlotte			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First PHOEBE Middle G. Last BERG				4. DATE OF DEATH Month Nov. Day 14 Year 1959			
5. SEX Female	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 9-1-1872	9. AGE (last birthday) 87	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) At Home			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) New York City, N. Y.		12. CITIZEN OF WHAT COUNTRY U. S. A.
13a. FATHER'S NAME Edgar G. Hoffman			13b. MOTHER'S MAIDEN NAME Kunigunde Lungen			14. NAME OF HUSBAND OR WIFE William Berg	
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. None		17. INFORMANT Address Phyllis L. Roegen, 4739 Charlotte, Kansas City, Missouri			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO (b) Arteriosclerotic Heart Disease DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH 30 hours 10 years	
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 11/57 to 11/14/59 and last saw her/him alive on 11/14/59 Death occurred at 11/14/59 10:30 a.m. on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) Otto W. Theel M.D.				22b. ADDRESS 4301 Main St. KC Mo.		22c. DATE SIGNED 11-16-59	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 11-17-1959	23c. NAME OF CEMETERY OR CREMATORY Mt. Washington		23d. LOCATION (City, town, or county) (State) Kansas City, Mo.		
24. FUNERAL DIRECTOR ADDRESS Stine & McClure Undertaking Co Kansas City, Missouri				25. DATE RECD. BY LOCAL REG. 11-16-59	26. REGISTRAR'S SIGNATURE Herb Marshall		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF Otto W. Theel

1:30 - 5 p.m.

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 JOE B. Yoder

Licensed Embalmer No. 4173

P. O. Address J.P. 2

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.