

**FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**=60-001676**

**FILED VS JAN 19 1960**

Registration District No. 149 Primary Registration District No. 1001 Registrar's No. 31 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo</b> b. COUNTY <b>Jackson</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kansas City</b>		c. CITY OR TOWN <b>Kansas City</b>	
Length of stay in 1b <b>25 yrs</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Trinity Lutheran</b>		d. STREET ADDRESS <b>3812 Highland</b> (If outside, give location)	
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) <b>LOUISE</b>	First <b>LOUISE</b>	Middle <b>H.</b>	Last <b>KRAUS</b>	4. DATE OF DEATH Month <b>1</b> Day <b>4</b> Year <b>60</b>
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5. SEX <b>Fe</b>	6. COLOR OR RACE <b>Wh</b>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>11-27-95</b>	9. AGE (last birthday) <b>64</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ret.</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Telephone Operator</b>	11. BIRTHPLACE (City and state or country) <b>Mo</b>	12. CITIZEN OF WHAT COUNTRY <b>USA</b>
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13a. FATHER'S NAME <b>Michael Kraus</b>	13b. MOTHER'S MAIDEN NAME <b>Caroline Truetzel</b>	14. NAME OF HUSBAND OR WIFE <b>xx</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	16. SOCIAL SECURITY NO. <b>xx</b>	17. INFORMANT <b>Thelka L. Kraus, 3812 Highland, MO Mo</b>	Address
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Nephritis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>Metastatic Carcinoma of left lung with pleural effusion.</b>	<b>?</b>
	DUE TO (c) <b>Carcinoma of Rectum</b>	<b>?</b>
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 checked="" type="checkbox"/> No <input type="checkbox"/> Unknown

19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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.)
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20c. TIME OF INJURY Hour <b>4:45</b> 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
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21. I attended the deceased from <b>Dec 31, 1959</b> to <b>Jan 3, 60</b> and last saw her alive on <b>Jan 3, 1960</b> Death occurred at <b>4:45 A.M.</b> on the date stated above, and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE (Degree or title) <b>John M. Powers M.D.</b>	22b. ADDRESS <b>3304 Linwood Blvd</b>	22c. DATE SIGNED <b>1/4/60</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>1-5-60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Riverview Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Jefferson City Mo</b>
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24. FUNERAL DIRECTOR <b>Wagner Funeral Home. K. C. Mo</b>	ADDRESS	25. DATE RECD. BY LOCAL REG. <b>1-4-60</b>	26. REGISTRAR'S SIGNATURE <b>Neva Minshall</b>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

John M. Powers

MAY 16 1961

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. Haunscher*

Licensed Embalmer No. 4159

P. O. Address R. C. W.

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.