

# RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS APR 26 1960

2032 -60-015323  
STATE FILE NUMBER

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

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Jackson</b>					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kansas City</b>		Length of stay in 1b <b>10 yrs.</b>		c. CITY OR TOWN <b>Kansas City</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>Colonial Nursing Home 100 E. 36th St.</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>7346 Arleta</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>Mrs. Lillian</b> Middle <b>Rotert</b> Last <b>Funk</b>				4. DATE OF DEATH Month <b>April</b> Day <b>11,</b> Year <b>1960</b>					
5. SEX <b>Fe</b>	6. COLOR OR RACE <b>Wh</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>5-30-80</b>	9. AGE (last birthday) <b>79 yrs.</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>At Home</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>		11. BIRTHPLACE (City and state or country) <b>Kansas City, Kansas</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>		
13a. FATHER'S NAME <b>Herman Rotert</b>			13b. MOTHER'S MAIDEN NAME <b>Frederika Kastrop</b>			14. NAME OF HUSBAND OR WIFE <b>Paul Funk (Deceased)</b>			
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>None</b>		17. INFORMANT Address <b>Mrs. Lillian Collins--1205 N. 18th St.</b>				
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>Cerebral vascular occlusion</b>							INTERVAL BETWEEN ONSET AND DEATH <b>1 mo</b>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Cerebral arteriosclerosis</b>							<b>10 yrs</b>		
DUE TO (c) <b>Generalized arteriosclerosis</b>							<b>19 yrs</b>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Auricular fibrillation</b>						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.)						
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 <b>4-19-60</b> to <b>4-11-60</b> and last saw her <sup>her</sup> alive on <b>4-9-60</b> Death occurred at <b>5:00 AM</b> on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Name or title) <b>John R. Whiteman MD</b>			22b. ADDRESS <b>631 1/2 Brookside Plaza</b>			22c. DATE SIGNED <b>4-11-60</b>			
22d. BURIAL, CREMATION, or REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>4-13-60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Highland Park Cemetery</b>		23d. LOCATION (City, town, or county) <b>Kansas City, Kansas</b>		(State)			
FUNERAL DIRECTOR ADDRESS <b>Gibson &amp; Son Funeral Home--K.C., K.</b>			25. DATE RECD. BY LOCAL REG. <b>4-11-60</b>		26. REGISTRAR'S SIGNATURE <b>Neva Minshall</b>				

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF John R. Whiteman

**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



Licensed Embalmer No. 3135

P. O. Address Keosauqua, Ia

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.