

URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-023367

FILED VS JUN 17 1960

STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 2962

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> 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>25 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>3023 E. 6th</b>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>3023 E. 6th</b>	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>WALTER</b> Middle <b>L. F.</b> Last <b>ROPCKE</b>			4. DATE OF DEATH Month <b>5</b> Day <b>30</b> Year <b>1960</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>5 1 1904</b>	9. AGE (last birthday) <b>56</b>	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Foreman</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>American Window</b>	11. BIRTHPLACE (City and state or country) <b>Antwerp Belgium</b>	12. CITIZEN OF WHAT COUNTRY <b>U. S. A</b>			
13a. FATHER'S NAME <b>Unknown</b>		13b. <del>GRANDFATHER'S</del> NAME <b>Unknown</b>		14. NAME OF HUSBAND OR WIFE <b>Katherine Ropcke</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>496 01 1096</b>	17. INFORMANT <b>Mrs. Katherine Ropcke 3023 E. 6th</b>
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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>Unknown</b>		INTERVAL BETWEEN ONSET AND DEATH <b>6 mo.</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>Congestive Heart Failure</b>	<b>1 yr.</b>
	DUE TO (c) <b>Cancer of lung</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Obesity</b>		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> N- <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 **Feb. 19, 1951** to **May 30, 1960** and last saw <sup>her</sup> him alive on **March 19, 1960**  
Death occurred at **2:30 A** m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <b>Glenn W. Springer, D.O.</b>	22b. ADDRESS <b>5902 St. John Ave. Kansas City, Mo.</b>	22c. DATE SIGNED <b>6-1-60</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>6-1-1960</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Floral Hills</b>
24. FUNERAL DIRECTOR <b>Floral Hills Memorial Chapel Inc</b>	ADDRESS <b>K.C. Mo</b>	23d. LOCATION (City, town, or county) (State) <b>Kansas City Missouri</b>
	25. DATE RECD. BY LOCAL REG. <b>6-1-60</b>	26. REGISTRAR'S SIGNATURE <b>Neva Minshall</b>

DOCUMENT  
BY AFFIDAVIT OF  
Glenn W. Springer MEDICAL CERTIFICATION

**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 Ernest D. Goldano

Licensed Embalmer No. 4714

P. O. Address R.P. 7100

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