

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

FILED VC AUG 29 1960

60-030776

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4140 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>JACKSON</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>JACKSON</u>									
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>KANSAS CITY</u>		Length of stay in 1b <u>—</u>		c. CITY OR TOWN <u>KANSAS CITY</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>							
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>NEUROLOGICAL HOSPITAL</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>5113 TROOST</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First <u>Philip</u> Middle <u>PETER</u> Last <u>ROLLHEISER</u>				4. DATE OF DEATH Month <u>8</u> Day <u>10</u> Year <u>1960</u>									
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>7/25/1884</u>		9. AGE (last birthday) <u>76</u>		IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u>		IF UNDER 24 HR Hours <u>—</u> Min. <u>—</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Supt.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>NEET PACKING</u>				11. BIRTHPLACE (City and state or country) <u>GERMANY</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>			
13a. FATHER'S NAME <u>CASPER ROLLHEISER</u>				13b. MOTHER'S MAIDEN NAME <u>BARBARA (UNKNOWN)</u>				14. NAME OF HUSBAND OR WIFE <u>MARGARET</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>496-01-4832</u>		17. INFORMANT Address <u>Mrs. MARGARET ROLLHEISER, 518 TROOST</u>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>BRONCHOPNEUMONIA</u>										INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>			
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) <u>DIABETES MELLITUS</u> <u>CHRONIC BRAIN SYNDROME ASSOCIATED WITH CEREBRAL ARTERIOSCLEROSIS</u>								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 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 _____ Month _____ Day _____ Year _____ a.m. _____ p.m. _____													
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 <u>24 JUN 1960</u> to <u>10 Aug 60</u> and last saw <sup>her</sup> him alive on <u>10 AUG 60</u> Death occurred at <u>4:45 AM</u> on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE <u>James W. Vaughn</u> (Degree or title) <u>MD</u>						22b. ADDRESS <u>2625 W. PASEO, KANSAS CITY, MO</u>			22c. DATE SIGNED <u>8/10/60</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>12 AUG 60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>CALVARY</u>				23d. LOCATION (City, town, or county) <u>K.C. Mo.</u>		(State)			
24. FUNERAL DIRECTOR'S NAME AND ADDRESS <u>MCGILLEY-ESTAR 1800 EAST LINWOOD, KANSAS CITY, MO</u>				25. DATE RECD. BY LOCAL REG. <u>8-11-60</u>				26. REGISTRAR'S SIGNATURE <u>H-S. Dwyer</u>					

DOCUMENT

BY AFFIDAVIT OF James W. Vaughn 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 me  
or by \_\_\_\_\_ Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed James E. Hochleiman

Licensed Embalmer No. 4572

P.O. Address \_\_\_\_\_

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.