

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-034739

FILED VS SEP 20 1960

149

Primary Registration District No. 1002

Registrar's No.

4577

STATE FILE NUMBER

ENDED

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri COUNTY Jackson	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City		Length of stay in 1b 36 Years	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 St. Mary's Hospital		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 3050 Harrison Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last LILLIAN B. FOGLEMAN			4. DATE OF DEATH Month Day Year Sept. 5, 1960
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 3-18-1875
9. AGE (last birthday) 85		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) Cainsville, Missouri
12. CITIZEN OF WHAT COUNTRY U. S. A.		13a. FATHER'S NAME Oxley Johnson	
13b. MOTHER'S MAIDEN NAME Martha Stalwart		14. NAME OF HUSBAND OR WIFE George Fogleman	
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 Mrs. Arch D. Paup Address Lexexa, Kansas
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 Thrombosis DUE TO (b) Arteriosclerotic Heart Dis + General DUE TO (c) Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH 48h.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Diabetic Mellitus			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 checked="" 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 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 51
21. I attended the deceased from Jan 1960 to Sept 5, 1960 and last saw her 9-4-60 alive on 9-4-60 Death occurred at 11:45 pm 9-4-60 on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Marcella M. Krahenbuhl, MD		22b. ADDRESS 4142 W 71 Prairie Village, Mo	22c. DATE SIGNED 9-5-60
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 9-8-60	23c. NAME OF CEMETERY OR CREMATORY Pleasant View	23d. LOCATION (City, town, or county) (State) Shawnee, Kansas
24. FUNERAL DIRECTOR Freeman Mortuary ADDRESS Kansas City, Mo.		25. DATE RECD. BY LOCAL REG. 9-7-60	26. REGISTRAR'S SIGNATURE H. L. Dwyer

DOCUMENT

BY AFFIDAVIT OF
Marcella M. Krahenbuhl
MEDICAL CERTIFICATION

DR. KRAHENBUHL

P. V. Medical

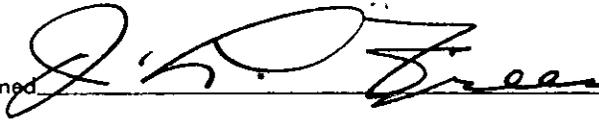
71-22 & Tomahawk

1-4:30

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. 293

P. O. Address F. C. 14

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