

FEDERAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-035019

FILED VS OCT 14 1960

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4975 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>3 yrs.</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>General Hospital</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>1631 Central</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>GEORGE</u> Middle <u>W</u> Last <u>SENGER</u>			4. DATE OF DEATH Month <u>10-</u> Day <u>1</u> Year <u>60</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>2-20-20</u>	9. AGE (last birthday) <u>40</u>	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Iron worker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Metal & Iron</u>	11. BIRTHPLACE (City and state or country) <u>Chicago, Illinois</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		
13a. FATHER'S NAME <u>George Fredrick Senger</u>		13b. MOTHER'S MAIDEN NAME <u>Calfern Biddle</u>		14. NAME OF HUSBAND OR WIFE <u>Evelyn Rath Senger</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes WW2</u>		16. SOCIAL SECURITY NO. <u>"unknown"</u>	17. INFORMANT <u>Mrs. Charlotte Barber</u> Address <u>Westfield, New Jersey 108 Park St.</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>Cerebral Infarction</u>					INTERVAL BETWEEN ONSET AND DEATH	
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)				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 _____ 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 <u>10-1-60</u> to <u>10-1-60</u> and last saw ^{them} him alive on <u>10-1-60</u> Death occurred at <u>10:20 p</u> on the date stated above, and to the best of my knowledge, from the causes stated.						
22a. SIGNATURE <u>H. L. Dwyer</u> (Degree or title)			22b. ADDRESS <u>N.D. 2400 Cherry st. - K.C., Mo.</u>		22c. DATE SIGNED <u>10-1-60</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>10-6-60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>National Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Fort Leavenworth, Kansas</u>			
24. FUNERAL DIRECTOR <u>WEILERT FUNERAL HOMES(S) K.C., MO.</u>		25. DATE RECD. BY LOCAL REG. <u>10-3-60</u>	26. REGISTRAR'S SIGNATURE <u>H. L. Dwyer</u>			

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF
H. L. Dwyer

1509

not not - 2 (undine?)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____, Student Embalmer No. _____ or by _____, Student Embalmer No. _____ working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed B. E. Weibert

Licensed Embalmer No. 4025
P. O. Address R. E. 8, 1

03-1-01

03-1-01

03-1-01

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.

03-1-01

03-1-01