

JURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-035215

FILED VS. SEP 27 1960

Registration District No. 150 Primary Registration District No. 5592 Registrar's No. 193

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY Jackson	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Prairie Twp.		Length of stay in 1b 0	c. CITY OR TOWN Lee's x Summit Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 71 By-pass Miles So. of #40 Highway		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) Old Independence Road Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last John Willis Stenger			4. DATE OF DEATH Month Day Year Sept. 18 1960			
5. SEX Male	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 7/28/07	9. AGE (last birthday) 53	IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Assistant To President		10b. KIND OF BUSINESS OR INDUSTRY Meat Processing		11. BIRTHPLACE (City and state or country) Kansas City Mo.		12. CITIZEN OF WHAT COUNTRY U S A
13a. FATHER'S NAME Arthur Stenger		13b. MOTHER'S MAIDEN NAME Lorraine Kinney		14. NAME OF HUSBAND OR WIFE Beatrice W. Stenger		
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. 486-10-0399		17. INFORMANT Address Beatrice W. Stenger Lee's Summit Mo.		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Shock & asphyxiation Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Crushed at chest numerous lacerations DUE TO (c) Lacerations		INTERVAL BETWEEN ONSET AND DEATH
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 type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input checked="" 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.) 71 By-pass Car Crash	
20c. TIME OF INJURY Hour a.m. p.m. 9-18-60	Month, Day, Year Collision	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Highway		20f. CITY, TOWN, OR LOCATION 71 By-pass Jackson	COUNTY STATE MO
21. I attended the deceased from _____ to _____ and last saw her/him alive on _____. Death occurred at _____ on the date stated above, and to the best of my knowledge, from the causes stated.			

22a. SIGNATURE (Degree or title) Herbert Owen Cornea		22b. ADDRESS 152 Marion Station		22c. DATE SIGNED 9-18-60
23a. BURIAL OR CREMATION (Specify) Burial	23b. DATE 9/21/1960	23c. NAME OF CEMETERY OR CREMATORY Lee's Summit		23d. LOCATION (City, town, or county) (State) Lee's Summit Mo.
24. FUNERAL DIRECTOR ADDRESS Langsford Funeral Home Lee's Summit Mo.		25. DATE RECD. BY LOCAL REG. 9-19-1960	26. REGISTRAR'S SIGNATURE M. B. Langsford	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

SEP 28 1960

MAY 9 1961

VS OCT 3 1960

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 D. B. Langford

Licensed Embalmer No. 496

P. O. Address Leisum

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.