

FEDERAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-041994

FILED VS NOV 17 1960

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 5417 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Jackson	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City		Length of stay in 2 wks.	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. Joseph Hospital		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 1259 W. 71st. Terr. Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) MR. WILLIAM J. FOELLNER	First Middle Last	4. DATE OF DEATH Oct. 28, 1960	Month Day Year
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5. SEX Male	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>	8. DATE OF BIRTH 4-20-1896	9. AGE (last birthday) 64	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Leavenworth, Kans.	12. CITIZEN OF WHAT COUNTRY U. S.
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13a. FATHER'S NAME Anthony Foellmer	13b. MOTHER'S MAIDEN NAME Catherine	14. NAME OF HUSBAND OR WIFE -
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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. 486-10-5060	17. INFORMANT Mrs. Elizabeth Roach Address 1259 W. 71st. Terr.
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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) Congestive Heart failure Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Cor pulmonale DUE TO (c) pulmonary fibrosis		INTERVAL BETWEEN ONSET AND DEATH 1 week ? yrs ? yrs.
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 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.)
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20c. TIME OF INJURY Hour a.m. p.m.	Month, Day, Year
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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 Kansas City, Mo.	COUNTY Leavenworth	STATE Kans.
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21. I attended the deceased from **Oct 25 '60** to **Oct 27 '60** and last saw her/him alive on **Oct 27 '60**
Death occurred at **4:15 am - Oct 28 - 1960** on the date stated above and to the best of my knowledge, from the causes stated.

22a. SIGNATURE R. Paul Wright M.D. (Degree or title)	22b. ADDRESS 1324 Prof. Bldg	22c. DATE SIGNED Oct 28 '60
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23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 10-31-60	23c. NAME OF CEMETERY OR CREMATORY Mt. Calvary	23d. LOCATION (City, town, county) Leavenworth, Kans. (State)
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24. FUNERAL DIRECTOR Melody-McGilley-Eyer ADDRESS 1800 E. Linwood	25. DATE RECD. BY LOCAL REG. 10-28-60	26. REGISTRAR'S SIGNATURE H. S. Dwyer
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BY AFFIDAVIT OF DOCUMENT MEDICAL CERTIFICATION

Dr. P
Prof. K

V12 -

4/11/12

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 James E. Kachle

Licensed Embalmer No. 4573

P. O. Address KC MO

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.