SSOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

-61-012429
STATE FILE NUMBER

AMENDED

Registration District No. 1 Primary Registration District No. 3000 Registrar's No. 104

FILED APR 24 1961

1. PLACE OF DEATH
a. COUNTY: Adair
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: Kirksville,
Length of stay in 1b: years
c. FULL NAME OF HOSPITAL OR INSTITUTION: ~~XXXX~~ Kirksville Osteopathic
Inside Limits: Yes ☐ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Mo. b. COUNTY: Adair
c. CITY OR TOWN: Kirksville
Inside Limits: Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location): 402 E. McPherson
Reside on Farm: Yes ☐ No ☒

3. NAME OF DECEASED (Type or print): First MATTIE Middle Last KUMM
4. DATE OF DEATH: Month April Day 15 Year 1961
5. SEX: Female
6. COLOR OR RACE: White
7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐
8. DATE OF BIRTH: 8/11/94
9. AGE (last birthday): 66
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): Homemaker
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (City and state or country): Macon Co/. Mo.
12. CITIZEN OF WHAT COUNTRY: U S
13a. FATHER'S NAME: Leige Faught
13b. MOTHER'S MAIDEN NAME: Virginia Unk.
14. NAME OF HUSBAND OR WIFE: Carl W. Kumm
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Carl W. Kumm, Address: Kirksville, Mo.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): pulmonary edema acute — INTERVAL BETWEEN ONSET AND DEATH: 2 days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): arteriosclerotic heart disease — 2 years
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. ☐ Yes ☒ No ☐ Unknown

DR. GUTENSOHN

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
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 ☐ NOT WHILE AT WORK ☐
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 1959, to April 15 1961 and last saw her alive on April 15, 1961
Death occurred at 11:24 p m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: M. Gutensohn (Degree or title) DO
22b. ADDRESS: Kirksville Mo
22c. DATE SIGNED: 4-17-61

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: Apr. 18/61
23c. NAME OF CEMETERY: Union
23d. LOCATION (City, town, or county) (State): Gibbs, Adair, Mo.

24. FUNERAL DIRECTOR ADDRESS: Foster Memorial Home, Kirksville, Mo.
25. DATE RECD. BY LOCAL REG.: 4-17-1961
26. REGISTRAR'S SIGNATURE: Doris W. Ratliff

(Licensed Embalmer's Statement on Reverse Side)

DATE AMENDED — INSTEAD OF — DOCUMENT — ITEM NO. — SHOULD READ — BY AFFIDAVIT OF

APR 26 1961

M. T. GUTENSOHN, D.O.

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 Nova E. Foster
Nova E. Foster

Licensed Embalmer No. 4742

P. O. Address Kirksville, Mo.

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.