

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

2531-61-017820
STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. _____

AMENDED

FILED JUN 5 1961

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| 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 1b 45 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 Research Hospital | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) 2307 East Meyer Blvd. |

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| 3. NAME OF DECEASED (Type or print) First Middle Last THEKLA E. TELGEMEIER | | | 4. DATE OF DEATH Month Day Year May 20 1961 | |
| 5. SEX Female | 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 3/18/96 | 9. AGE (last birthday) 65 |

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| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker-Housewife | 10b. KIND OF BUSINESS OR INDUSTRY Domestic | 11. BIRTHPLACE (City and state or country) Concordia, Missouri | 12. CITIZEN OF WHAT COUNTRY U.S.A. |
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| 13a. FATHER'S NAME Louis Klosterman | 13b. MOTHER'S MAIDEN NAME Pauline Kronsbein | 14. NAME OF HUSBAND OR WIFE Albert H. Telgemeier |
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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. None | 17. INFORMANT Albert H. Telgemeier, 2307 E. Meyer | Address Kansas City, Mo |
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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: | | INTERVAL BETWEEN ONSET AND DEATH 2 yrs |
| IMMEDIATE CAUSE (a) Carcinoma of the | | |
| DUE TO (b) Carcinoma L. Breast | | |
| DUE TO (c) _____ | | |

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| 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 |
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| 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. _____ | 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 |
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| 21. I attended the deceased from Nov 1949 to May 1961 and last saw her alive on May 20, 1961 Death occurred at 9:45 A. m on the date stated above, and to the best of my knowledge, from the causes stated. | |
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| 22a. SIGNATURE Robert C. Mc Clanahan | (Degree or title) | 22b. ADDRESS 820 Professional Center | 22c. DATE SIGNED 5/21/61 |
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| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE May 22, 1961 | 23c. NAME OF CEMETERY OR CREMATORY Forest Hill Cemetery | 23d. LOCATION (City, town, or county) Kansas City Missouri |
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| 24. FUNERAL DIRECTOR D.W. Newcomer's Sons, Kansas City, Mo. | 25. DATE RECD. BY LOCAL REG. 5-22-61 | 26. REGISTRAR'S SIGNATURE Ruth Long |
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(Licensed Embalmer's Statement on Reverse Side)

DATE AMENDED
 INSTEAD OF
 DOCUMENT
 BY AFFIDAVIT OF
 Robert C. Mc Clanahan
 MEDICAL CERTIFICATION
 ITEM NO. SHOULD READ

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 Levek, Michael

Licensed Embalmer No. 4340

P. O. Address K.C., 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.