

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-029250
STATE FILE NUMBER

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4178

Filed SEP 8 1961

DATE AMENDED

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH
a. COUNTY Jackson
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City Length of stay in 1b life
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 8450 Oldham Rd. Inside Limits Yes No

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY Jackson
c. CITY OR TOWN Kansas City Inside Limits Yes No
d. STREET ADDRESS (If outside, give location) 8450 Oldham Rd. Reside on Farm Yes No

3. NAME OF DECEASED (Type or print) First John Middle B. Last Fehlig 4. DATE OF DEATH Month August Day 22 Year 1961

5. SEX male 6. COLOR OR RACE white 7. Married Never Married Widowed Divorced 8. DATE OF BIRTH 11-23-1899 9. AGE (last birthday) 61 IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HR

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) manager 10b. KIND OF BUSINESS OR INDUSTRY Excelsior Heating 11. BIRTHPLACE (City and state or country) Kansas City, Missouri 12. CITIZEN OF WHAT COUNTRY U. S. A.

13a. FATHER'S NAME John B. Fehlig 13b. MOTHER'S MAIDEN NAME Anne Smith 14. NAME OF HUSBAND OR WIFE Janice Fehlig

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) yes WW#1-Army 17. INFORMANT Address Mrs. Jancie Fehlig 8450 Oldham Rd.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Stroke ~~from~~ Epilepsy
DUE TO (b) Arteriosclerosis
DUE TO (c) _____
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Periodic Convulsions several yrs
PART III. If deceased was female was there a pregnancy in last 90 days. Yes No Unknown

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 _____ 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 _____ 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) Ruth Long 22b. ADDRESS 157 Union Station 22c. DATE SIGNED 8-28-61

23a. BURIAL, CREMATION, REMOVAL (Specify) burial 23b. DATE 8-26-61 23c. NAME OF CEMETERY OR CREMATORY Forest Hill 23d. LOCATION (City, town, or county) (State) Kansas City, Missouri

24. FUNERAL DIRECTOR Mellody-McGilley-Eylar ADDRESS 1800 E. Linwood 25. DATE RECD. BY LOCAL REG. 8-22-61 26. REGISTRAR'S SIGNATURE Ruth Long

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 James E. Kachilemo

Licensed Embalmer No. 4573

P. O. Address H. P. 710

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.