

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-032875

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4805

STATE FILE NUMBER

AMENDED

FILED 08111961

1. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY Jackson	a. STATE Mo.	b. COUNTY Jackson	admission)
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City	Length of stay in 1b 75 yrs	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 4234 Genessee	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 4234 Genessee	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last ROSE GUMINGER	4. DATE OF DEATH Month Day Year 9 25 61
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5. SEX Fe	6. COLOR OR RACE Wh	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 5-13-73	9. AGE (last birthday) 88.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home	10b. KIND OF BUSINESS OR INDUSTRY xx	11. BIRTHPLACE (City and state or country) Germany	12. CITIZEN OF WHAT COUNTRY USA
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13a. FATHER'S NAME Frank Eppinger	13b. MOTHER'S MAIDEN NAME Maria Scheidel	14. NAME OF HUSBAND OR WIFE Alois Guminger
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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 xx	17. INFORMANT Address Mrs. Rose Davis 4234 Genessee
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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
IMMEDIATE CAUSE (a)	Acute Cardiac Failure	2 days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Hypertensive Cardiovascular disease	2 yrs.
	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. <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.) None
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20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year	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 Oct 1951 to 9-25-61 and last saw her alive on 9-22-61. Death occurred at 8:15 A.M. on the date stated above, and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE (Degree or title) James W Downey M.D.	22b. ADDRESS 425 E 63rd K.C. Mo.	22c. DATE SIGNED 9/27/61
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23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 9-28-61	23c. NAME OF CEMETERY OR CREMATORY St. Joseph Cemetery	23d. LOCATION (City, town, or county) Shawnee, Kansas (State)
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24. FUNERAL DIRECTOR ADDRESS WAGNER FUNERAL HOME, K.C. Mo.	25. DATE RECD. BY LOCAL REG. 9-27-61	26. REGISTRAR'S SIGNATURE Ruth Long
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(Licensed Embalmer's Statement on Reverse Side)

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS  
 DATE AMENDED  
 INSTEAD OF  
 DOCUMENT  
 MEDICAL CERTIFICATION  
 BY AFFIDAVIT OF  
 James W. Downey  
 ITEM NO. SHOULD READ

2-3 P.M. WED.

**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 Alvin R. Hauschek

Licensed Embalmer No. 4159

P. O. Address P. O. 714

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.