

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

6094

-61-044529

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 6094

STATE FILE NUMBER

AMENDED

FILED DEC 22 1961

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 5 yrs	c. CITY OR TOWN Kansas City
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 4712 Roanoke Parkway		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 4712 Roanoke Parkway
			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Margaret Middle A. Last Budinger	4. DATE OF DEATH Month December Day 5 Year 1961
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5. SEX Female	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 6-14-1870	9. AGE (last birthday) 91	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/>	IF UNDER 24 HR Hours <input type="checkbox"/> Min. <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (City and state or country) Chicago, Illinois		12. CITIZEN OF WHAT COUNTRY USA	

13a. FATHER'S NAME Peter Birong	13b. MOTHER'S MAIDEN NAME Elizabeth Reinhart	14. NAME OF HUSBAND OR WIFE John P. Budinger
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. 162-35-920	17. INFORMANT Address J. A. Budinger, 4712 Roanoke Pkwy, K.C. Mo.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of colon with metastases		INTERVAL BETWEEN ONSET AND DEATH 2 yrs.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ 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

19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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.)
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 _____
21. I attended the deceased from Jan 1960 to Dec 4, 1961 and last saw her alive on Dec 4, 1961 Death occurred at 5:00 AM on the date stated above, and to the best of my knowledge, from the causes stated.		

22a. SIGNATURE (Degree or title) Albert I. Decker MD	22b. ADDRESS Kansas City, Mo.	22c. DATE SIGNED 12-5-61
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23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 12-5-61	23c. NAME OF CEMETERY OR CREMATORY All Saints Cemetery	23d. LOCATION (City, town, or county) Des Plaines, Illinois
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24. FUNERAL DIRECTOR Melody-McGilley-Eylar, 20 W. Linwood	25. DATE RECD. BY LOCAL REG. 12-5-61	26. REGISTRAR'S SIGNATURE Ruth Long
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K. C. Mo. (Licensed Embalmer's Statement on Reverse Side)

INSIDE OF

DOCUMENT

ITEM NO. SHOULD READ

BY AFFIDAVIT OF Albert I. Decker MEDICAL CERTIFICATION

JAN 16 1962

Dr. Deen
Kaldkei

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 _____

Wm H. Benty

Licensed Embalmer No. _____

05038

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.