

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=62-026409

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 72 Primary Registration District No. 3013 Registrar's No. 132

FILED AUG 13 1962	
1. PLACE OF DEATH a. COUNTY <u>Clay</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>North Kansas City</u> Length of stay in 1b <u>13 days</u> c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>North Kansas City Memorial</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Clay</u> c. CITY OR TOWN <u>Kansas City 18</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>7014 No. Troost</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Walter</u> Middle <u>(None)</u> Last <u>GERMAN</u>	
4. DATE OF DEATH Month <u>August</u> Day <u>7</u> Year <u>1962</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>
7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>2-22-88</u>
9. AGE (last birthday) IF UNDER 1 YEAR IF UNDER 24 HR <u>74</u> Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Agriculture</u>
11. BIRTHPLACE (City and state or country) <u>Gower, Mo.</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
13a. FATHER'S NAME <u>William A. German</u>	13b. MOTHER'S MAIDEN NAME <u>Sarah Katherine Fiddler</u>
14. NAME OF HUSBAND OR WIFE <u>Della Maude German</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	16. SOCIAL SECURITY NO.
17. INFORMANT <u>Howard German</u> Address <u>612 E. 71st St. W.K.C., MO</u>	
18. CAUSE OF DEATH (Enter only one cause per line for PART I. DEATH WAS CAUSED BY:	
IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u>	
DUE TO (b) <u>Pulmonary atelectasis</u>	
DUE TO (c) 	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Post-operative gastroenterostomy for carcinoma of stomach</u>	
PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" 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 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 <u>July 28, 1962</u> to <u>Aug. 7, 1962</u> and last saw her/him alive on <u>Aug. 7, 1962</u> Death occurred at <u>5:50 P</u> m on the date stated above, and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE <u>L.M. Robert, M.D.</u> (degree or title)	22b. ADDRESS <u>5140 Antioch Rd Kansas City 18, Mo</u>
22c. DATE SIGNED <u>8-7-62</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>8-10-1962</u>
23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Zion Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Clinton Co. Mo.</u>
24. FUNERAL DIRECTOR <u>Clarence E. Wilson - Gower, Mo</u>	25. DATE RECD. BY LOCAL REG. <u>8-9-62</u>
26. REGISTRAR'S SIGNATURE <u>Marguerite Hudgens</u>	

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DATE AMENDED
AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
INSTEAD OF
ITEM NO. SHOULD READ

DOCUMENT
MEDICAL CERTIFICATION
BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

AUG 14 1962

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 Clarence E. Hipson

Licensed Embalmer No. 5122

P. O. Address Tower, 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.