

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-039028

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 5443

FILED NOV 9 1962

VS 300
Rev. 4/59

1
3/6/68
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4 1
5 1
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9 451X
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12 66-0
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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

Philip G. Kaul

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		c. CITY OR TOWN Kansas City	
Length of stay in lb 32 yrs.		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION Saint Lukes Hospital		d. STREET ADDRESS (If outside, give location) 216 Brush Creek Apt 2	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) M Josephine Warner			4. DATE OF DEATH Month October Day 24 Year 1962				
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 2-22-98	9. AGE (last birthday) 64 Yrs	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) St. Louis, Missouri		12. CITIZEN OF WHAT COUNTRY U. S. A.	
13a. FATHER'S NAME Charles Leonhard			13b. MOTHER'S MAIDEN NAME Josephine Tricar		14. NAME OF HUSBAND OR WIFE Philip H. Warner		
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. -		17. INFORMANT Philip H. Warner Address 216 Brush Creek		

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) Cardiac Arrest & Persistent Shock			12 Hrs.
DUE TO (b) Post operative resection of			16 Hrs.
DUE TO (c) Aneurysm abdominal aorta.			6 weeks.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) ① Arteriosclerotic Heart Disease. ② Hypertensive Cardiovascular Disease.			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 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.)	
20c. TIME OF INJURY Hour 11:50 a.m. / p.m. Month, Day, Year Feb. 1952			
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" 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 Feb. 1952 to 24 October, 1962 and last saw ^(her) her live on 24 Oct. 1962 . Death occurred at 11:50 A. m on the date stated above, and to the best of my knowledge, from the causes stated.			

22a. SIGNATURE (Degree or title) Philip G. Kaul M.D.		22b. ADDRESS 7320 Wornall Rd.		22c. DATE SIGNED 10-25-1962
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 10-27-62	23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet	23d. LOCATION (City, town, or county) (State) Kansas City, Missouri	
24. FUNERAL DIRECTOR ADDRESS Stine & McClure, Kansas City, Mo.		25. DATE RECD. BY LOCAL REG. 10-26-62	26. REGISTRAR'S SIGNATURE Ruth Long	

USE BLACK INK OR TYPEWRITER RIBBON

*The City Hall
4320 W. Howell Rd.
PC-1-2338
1:00 - 5 pm*

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 *William M. Turner*

Licensed Embalmer No. *4648*
P. O. Address *Kansas City, 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.