

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=63-006290

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 970 STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

VS 300
Rev. 4/59

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DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

BY AFFIDAVIT OF Frank B. Leitz MEDICAL CERTIFICATION

<p style="font-size: 18pt; font-weight: bold;">FILED MAR 8 1963</p>		<p>1. PLACE OF DEATH a. COUNTY <u>JACKSON</u></p>		<p>2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>KANSAS</u> b. COUNTY <u>WYANDOTTE</u></p>	
<p>b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>KANSAS CITY</u></p>		<p>Length of stay in 7b <u>1-HOUR</u></p>		<p>c. CITY OR TOWN <u>KANSAS CITY</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	
<p>c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>RESEARCH HOSPITAL</u></p>		<p>Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>		<p>d. STREET ADDRESS (If outside, give location) <u>1316 CLEVELAND</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/></p>	
<p>3. NAME OF DECEASED (Type or print) First <u>OTTO</u> Middle <u>V.</u> Last <u>ASEL</u></p>			<p>4. DATE OF DEATH Month <u>FEBRUARY</u> Day <u>10</u> Year <u>1963</u></p>		
<p>5. SEX <u>MALE</u></p>	<p>6. COLOR OR RACE <u>WHITE</u></p>	<p>7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/></p>	<p>8. DATE OF BIRTH <u>6/18/1890</u></p>	<p>9. AGE (last birthday) <u>72</u> IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.</p>	
<p>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>OPTOMETRIST</u></p>		<p>10b. KIND OF BUSINESS OR INDUSTRY <u>GOLDMAN JEWELRY CO. R.O.M.O.</u></p>		<p>11. BIRTHPLACE (City and state or country) <u>JEFFERSON CITY, MO.</u></p>	
<p>12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u></p>		<p>13a. FATHER'S NAME <u>JOHN G. ASEL</u></p>		<p>13b. MOTHER'S MAIDEN NAME <u>JOHANNAH BONNENBERGER - MRS. OLIVE</u></p>	
<p>14. NAME OF HUSBAND OR WIFE <u>MRS. DONALD HENDREN</u></p>		<p>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u></p>		<p>16. SOCIAL SECURITY NO. <u>[REDACTED]</u></p>	
<p>17. INFORMANT Address <u>1628 CLEVELAND, KANSAS CITY, KS</u></p>		<p>18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>M Pulmonary Infarction</u> INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u> DUE TO (b) <u>Hypertension - arteriosclerotic Heart disease</u> <u>seen year</u> DUE TO (c) <u>decompensation</u> <u>2 month</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.</p>			
<p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I <u>Marked Hypertrophy of Prostate</u></p>				<p>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</p>	
<p>19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p>	<p>20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOACIDE <input type="checkbox"/></p>	<p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)</p>			
<p>20c. TIME OF INJURY Hour _____ Month, Day, Year _____ p.m.</p>					
<p>20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/></p>		<p>20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>		<p>20f. CITY, TOWN, OR LOCATION COUNTY STATE</p>	
<p>21. I attended the deceased from <u>Jan 28 1963</u> to <u>Feb 10 1963</u> and last saw him alive on <u>Feb 8 1963</u> Death occurred at <u>4:45</u> p.m. on the date stated above, and to the best of my knowledge, from the causes stated.</p>					
<p>SIGNATURE (Degree or title) <u>Frank B. Leitz M.D.</u></p>			<p>22b. ADDRESS <u>1530 Prof. Bldg. Univ. of Mo.</u></p>		<p>22c. DATE SIGNED <u>2-13-63</u></p>
<p>23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u></p>		<p>23b. DATE <u>FEB. 13 1963</u></p>	<p>23c. NAME OF CEMETERY OR CREMATORY <u>HIGHLAND PARK CEMETERY</u></p>		<p>23d. LOCATION (City, town, or county) (State) <u>KANSAS CITY KANSAS</u></p>
<p>24. FUNERAL DIRECTOR ADDRESS <u>D.W. NEWCOMER'S SONS 1817 + BARNETT KANSAS CITY, KS</u></p>		<p>25. DATE RECD. BY LOCAL REG. <u>2-13-63</u></p>	<p>26. REGISTRAR'S SIGNATURE <u>Ruth Long</u></p>		

USE BLACK INK OR TYPEWRITER RIBBON

Dr. Frank B. Polity
Clinic - 107 West Broadway
10:30 - 11:15
T-10

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 Harold S. Bitternacht

Licensed Embalmer No. 3035

P. O. Address W. C. Hansen

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.