

Registration District No. 399

Primary Registration District No. 1002

1. PLACE OF DEATH:

(a) County Jackson  
(b) City or town Kansas City, Mo.  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: 3923 Roanoke Road, ✓  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution X (Specify whether  
In this community Unknown,  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri, (b) County Jackson,  
(c) City or town Kansas City, Missouri,  
(If outside city or town limits, write "RURAL")  
(d) Street No. 3923 Roanoke Road,  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month December day 7,  
year 1939 hour 1:30 P. minute \* M.  
21. I hereby certify that I attended the deceased from Aug 22  
1939 to Dec 7, 1939  
that I last saw him alive on Dec 5, 1939  
and that death occurred on the date and hour stated above.  
Immediate cause of death Uremia

Due to chronic nephritis 10 yrs  
chronic cystitis 10 yrs  
Due to 10!  
Other conditions the myocarditis  
(include pregnancy within 3 months of death)  
arterio-sclerosis

Major findings: apnoea  
Of operations: apnoea  
Of autopsy: no autopsy

Duration  
38 yrs

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
(b) Date of occurrence \_\_\_\_\_  
(c) Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_  
While at work? \_\_\_\_\_ (Specify type of place)  
(e) Means of injury \_\_\_\_\_

23. Signature H. M. Valentine (M. D. or other)  
Address 1240 ... Date signed Dec 7  
1939

3. (a) PRINT FULL NAME

William Engelbach, 524

3. (b) If veteran,

name war X

3. (c) Social Security

No. X

4. Sex Male

5. Color or race White

6. (a) Single, widowed, married, divorced Widowed,

6. (b) Name of husband or wife

Laura Engelbach,

6. (c) Age of husband or wife if

alive \_\_\_\_\_ years

7. Birth date of deceased

October,  
(Month)

21, 1848,  
(Day) (Year)

8. AGE:

Years

Months

Days

If less than one day

91

1

16

hr. \_\_\_\_\_ min.

9. Birthplace

Pennsylvania,

(City, town, or county)

(State or foreign country)

10. Usual occupation

none,

11. Industry or business

X

MOTHER FATHER

12. Name John F. Engelbach,

13. Birthplace

Germany,

(State or foreign country)

14. Maiden name

Unknown,

15. Birthplace

Unknown,

(State or foreign country)

16. (a) Informant's own signature

O. M. Engelbach,

(b) Address

3923 Roanoke Road, K. C., Mo.

17. (a) Burial,

(b) Date thereof

12-7-39

(Burial, cremation, or removal)

(Month) (Day) (Year)

(c) Place: burial or cremation

Edinburg, Ind.

18. (a) Signature of funeral director

Stine & McClure,

(b) Address

3235 Gillham Plaza, K. C., Mo.

19. (a) Dec. 7, 1939

(Date received local registrar)

M. M. Crowe  
(Registrar's signature)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

Dr. H. S. Valentine.

Conf. - V, 1938.

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**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.....

....., Registered Apprentice No. ....

working under my personal supervision.

Signed

*J. B. Waters*

Licensed Embalmer No. *3992*

P. O. Address *14 C M.*

**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 this body is not embalmed, above space should be left blank.**