

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.

Registration District No. _____ Primary Registration District No. _____

1. PLACE OF DEATH:
 (a) County Jackson
 (b) City or town Kansas City
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
3930 Clark Street
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____ (Specify whether
 In this community 65 Years
 years, months or days)

3. (a) PRINT FULL NAME John Pfahler
 3. (b) If veteran, name war No
 3. (c) Social Security No. No

4. Sex Male 5. Color or race White
 6. (a) Single, widowed, married, divorced Single
 6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if
 alive _____ years
 7. Birth date of deceased June 18, 1868
 (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>71</u>	<u>6</u>	<u>26</u>	_____ hr. _____ min.

9. Birthplace Indiana
 (City, town, or county) (State or foreign country)

10. Usual occupation Secretary Westport

11. Industry or business Masonic Lodge

12. Name George Pfahler
 13. Birthplace Germany
 (City, town, or county) (State or foreign country)

14. Maiden name Caroline Rauber
 15. Birthplace Germany
 (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Frank Pfahler
 (b) Address Wilmette, Ill.

17. (a) Burial (b) Date thereof 1-16-40
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Elmwood

18. (a) Signature of funeral director Freeman Mortuary
 (b) Address Kansas City, Mo

19. (a) Jan. 15, 1940 (b) M. M. Browne
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County Jackson
 (c) City or town Kansas City
 (If outside city or town limits, write "RURAL")
 (d) Street No. 3930 Clark Street
 (If rural, give location)
 (e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month Jan day 14
 year 1940 hour 10 minute 9 M.
 21. I hereby certify that I attended the deceased from
Nov., 1939, to Jan. 14, 1940
 that I last saw him alive on Jan 14/40
 and that death occurred on the date and how stated above.

Immediate cause of death	Duration
<u>Coronary Occlusion</u>	<u>10 min</u>
Due to <u>Arterio-sclerosis of aorta</u>	
Due to _____	
Other conditions <u>Auric Fibrillation</u> (Include pregnancy within 3 months of death)	

Major findings:
 Of operations _____
 Of autopsy _____

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 W. S. Washington (M. D. or other) MD
 Address W. S. Washington, Beth Date signed 1/15/40

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 Edmund C. Wedekin

Licensed Embalmer No. 3495

P. O. Address St. C. Missouri

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.