

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAR 11 1940

Registration District No. 299

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 1002

State File No. _____

5475

Registrar's No. 700

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Raw / Kansas City, Mo
(c) Name of hospital or institution: St. Marys Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 4 days
In this community 4 1/2 years
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson
(c) City or town Jackson Kansas City, Mo
(If outside city or town limits, write "RURAL")
(d) Street No. 2736 Cherry
(If rural, give location)
(e) If foreign born, how long in U. S. A. ? _____ years

3. (a) PRINT FULL NAME May Emil Kaelzel

3. (b) If veteran, name war none 3. (c) Social Security No. None

4. Sex M 5. Color or race wh 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 Unknown 1871
(Month) (Day) (Year)

8. AGE: Years 69 Months -- Days -- If less than one day hr. _____ min.

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

10. Usual occupation Labourer - U. S. Navy

11. Industry or business _____

MOTHER FATHER { 12. Name No Record 9
13. Birthplace (City, town, or county) (State or foreign country)

{ 14. Maiden name No Record 9
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Mrs. A. Kaelzel
(b) Address 2728 Gilliam

17. (a) Burial (b) Date thereof 2-17-40
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Floral Hills

18. (a) Signature of funeral director Bensley Hartung
(b) Address 5811 Street

19. (a) Feb 16 '40 (b) Mmlawer
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb 15 day 1940
year _____ hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from Feb 12, 1940 to Feb 15, 1940
that I last saw him alive on Feb 15, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death acute appendicitis Duration
& General Peritonitis

Due to 121
Due to _____

Other conditions Decubiti
(Include pregnancy within 3 months of death)

Major findings: Of operations _____
Of autopsy Yes

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 N. Allen (M. D. or other)
Address 34 Reelle Bldg R. Mo Date signed 2-16-40

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 GUY F. BUFFINGTON

....., Registered Apprentice No.
working under my personal supervision.

Signed Guy Buffington

Licensed Embalmer No. 2756

P. O. Address K C New

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.