

FILED NOV 12 1940
399

Registration District No. _____ Primary Registration District No. **1002**

Registrar's No. **4159**

1. PLACE OF DEATH: **Jackson**
(a) County _____
(b) City or town **Kansas City**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **General Hospital**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **8 1/2 days**
In this community **All his life** (Specify whether years, months or days)

3. (a) PRINT FULL NAME **Rudolph Hirt**

3. (b) If veteran, name war **No** 3. (c) Social Security No. **510-05-0430**

4. Sex **Male** 5. Color or race **Wh** 6. (a) Single, widowed, married, divorced **Divorced**

6. (b) Name of husband or wife **Anna Hirt** 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased: **April 24 1889**
(Month) (Day) (Year)

8. AGE: Years **51** Months **6** Days **6** If less than one day hr. _____ min. _____

9. Birthplace **Kansas City Mo. D**
(City, town, or county) (State or foreign country)

10. Usual occupation **Employee**

11. Industry or business **K.C. Structural Steel Co.**

12. Name **Jacob Hirt**

13. Birthplace **Germany**
(City, town, or county) (State or foreign country)

14. Maiden name **Mary Lemke**

15. Birthplace **Germany**
(City, town, or county) (State or foreign country)

16. (a) Informant **Wm. Hirt**

(b) Address **2907 N. 30th. KCK**

17. (a) **Burial** (b) Date thereof **11-1-40**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Forest Hill**

18. (a) Signature of funeral director **J.W. Wagner**

(b) Address **Kansas City, Mo.**

19. (a) **10-31-40** (b) **M. M. Crowe**
(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. **3622 Wabash**
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Oct.** day **30th** year **1940** hour **5** minute **15** A. M.

21. I hereby certify that I attended the deceased from _____ to _____, 19____; that I last saw _____ live on _____, 19____; and that death occurred on the date and hour stated above. Immediate cause of death: _____

**Subdural & subarachnoid
Due to cerebral hemorrhage
Laceration of the brain
Fracture of the skull 195**

Other conditions **Traumatic injury to head**
(Include pregnancy within 3 months of death)

Major findings: _____
Of operations _____
Of autopsy **yes**

Duration

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 **DO NOT KNOW**

(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) _____ (Specify nature of injury) **5**

23. Signature **Wm. Hirt** (M. D. or other) _____
Address **K.C. Mo.** Date signed _____

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

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

A. P. Haunschild

Licensed Embalmer No.

4159

P. O. Address

K.C. 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 this body is not embalmed, fact should be so stated above.