S. No. 2
-11-10-39
5-17-39
I X21492

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 37817

Registration District No. 399 Primary Registration District No. 1002 Registrar's No. 4415

FILED DEC 11 1940

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: Research
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 9 Days (Specify whether
In this community Non-Resident
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Cass

(c) City or town Harrisonville Mo
(If outside city or town limits, write "RURAL")

(d) Street No. 5035 Lexington St
(If rural, give location)

(e) If foreign born, how long in U. S. A.? — years.

3. (a) PRINT FULL NAME Ora L. Koontz

3. (b) If veteran, name war ✓

3. (c) Social Security No. 702-10-9862

4. Sex Male

5. Color or race white

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

6. (b) Name of husband or wife Jona F. Koontz

6. (c) Age of husband or wife if alive 67 years

7. Birth date of deceased Oct 26 - 1871
(Month) (Day) (Year)

8. AGE: Years 69 Months — Days 23 If less than one day ___ hr. ___ min.

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

10. Usual occupation Rail way Employe

11. Industry or business Agent & Telegraf Operator

FATHER
12. Name John Koontz
13. Birthplace West Virginia
(City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Rachel McCormack
15. Birthplace Indiana
(City, town, or county) (State or foreign country)

16. (a) Informant Jona F. Koontz
(b) Address Harrisonville Mo

17. (a) _____ (Burial, ~~cremation, or removal~~) (b) Date thereof ~~Oct~~ 22-40
(Month) (Day) (Year)
(c) Place: burial or ~~cremation~~ Harrisonville Mo

18. (a) Signature of funeral director Rummenburger
(b) Address Harrisonville Mo

19. (a) 11-19-40 (Date received local registrar) (b) M. M. Crowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 19
year 1940 hour one minute 30 P. M.

21. I hereby certify that I attended the deceased from _____, 19__, to _____, 19__;
that I last saw him alive on 11-19, 1940
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Pneumonia	
Due to Compound comminuted Fracture left leg	
Due to Gas gangrene	
Other conditions (Include pregnancy within 3 months of death) 184	

Major findings:
Of operations Welch Baby culture
Of autopsy No

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) Accident
(b) Date of occurrence 11-10-1940
(c) Where did injury occur? Near Harrisonville Mo
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
Hunting Accident
(Specify type of place)
While at work? _____ (e) Means of injury Gunshot

23. Signature J. G. Montgomery (M. D. or other)
Address Prof Bldg Date signed 11/19/40

(Licensed Embalmer's Statement on Reverse Side)

DEC 18 1946

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 Frank E Rimmenburger

Licensed Embalmer No. 2681

P. O. Address Harrisonville

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.