

JAN 10 1941

399

Registration District No. _____

Primary Registration District No. _____

1. PLACE OF DEATH:
(a) County Jackson
(b) City or town Kansas City
(c) Name of hospital or institution: St. Mary's Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 days
(Specify whether
In this community 12 years
years, months or days)

3. (a) PRINT FULL NAME Barbara Dagen

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

4. Sex Female race White 5. Color or divorced Widowed
6. (b) Name of husband or wife Casper Dagen 6. (c) Age of husband or wife if Oct. 7 1851
7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
89 2 11 hr. min.

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

10. Usual occupation At Home

11. Industry or business _____

12. Name George Jacob

18. Birthplace Germany
(State or foreign country)

14. Maiden name Marie (Jacob)

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

16. (a) Informant's own signature Mrs. Elizabeth Dagen

(b) Address 3619 Wyandotte, K. C. Mo.

17. (a) Removal (b) Date thereof 12-19-1940
(Burial, cremation, or removal) (City or town) (County) (State) (Year)
Topeka, Kansas

(c) Place: burial or cremation St. O'Donnell's

18. (a) Signature of funeral director J. O'Donnell

(b) Address 3256 Broadway, K. C., Mo.

19. (a) 12-18-40 (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. 3619 Wyandotte
(If rural, give location) 50
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 18
year 1940 hour 4 minute 30 A. M.

21. I hereby certify that I attended the deceased from Dec. 16
1940 to Dec. 18, 1940
that I last saw her alive on Dec. 17, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary embolism - 6 hrs
Due to Bronchopneumonia 2 days
Due to 10/1/40

Other conditions Paroxysmal Atrial Fibrillation 2 days
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____
Of autopsy _____
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) none
(b) Date of occurrence none
(c) Where did injury occur? none
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
361 (Specify type of place) _____
While at work? _____ (e) Means of injury _____
23. Signature Graham Asher (M. D. or other) med.
Address 1220 Prof. Bldg. Date signed 12-18-40

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

REV. 6-17-39 I X19311

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.

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.....

Licensed Embalmer No.....

P. O. Address.....

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.