

Registration District No. **399**

Primary Registration District No. **1002**

Registrar's No. **23**

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

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:
K.C. General Hospital
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution **1 Mo. & 8 days**
 (Specify whether _____)
 In this community **Life**
 years, months or days)

8. (a) PRINT FULL NAME **CHARLES FEHR**

8. (b) If veteran, name war **700**

3. (c) Social Security No. **494-14-1716**

4. Sex **Male** 5. Color or race **white**

6. (b) Name of husband or wife **Ida May Fehr**

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

6. (c) Age of husband or wife if alive **41** years

7. Birth date of deceased **July 26 1871**
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	69	5	5	hr. _____ min.

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

10. Usual occupation **Mechanics**

11. Industry or business **✓**

12. Name **Werkman**

18. Birthplace **Werkman** 9
(City, town, or county) (State or foreign country)

14. Maiden name **Werkman**

15. Birthplace **Werkman** 9
(City, town, or county) (State or foreign country)

16. (a) Informant **Ida May Fehr**

(b) Address **220 W 34th St**

17. (a) **Burial** (b) Date thereof **1/4/41**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Plebs Grove Md**

18. (a) Signature of funeral director **Wayne Snow**

(b) Address **2315 Chestnut**

19. (a) **Jan 3, 1941** (b) **J. M. M. Crowe**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State **Missouri** (b) County **Jackson** **48**
 (c) City or town **Kansas City** **3**
 (If outside city or town limits, write "RURAL") **0**
 (d) Street No. **220 West 34th St.** **0**
 (If rural, give location)
 (e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Jan** day **1st**
year **1941** hour **5** minute **21 P.** M.

21. I hereby certify that I attended the deceased from **11-24-40**, 19____, to **1-1-41**, 19____;

that I last saw him alive on **1-1-41**, 19____;

and that death occurred on the date and hour stated above.

Immediate cause of death **Carcinoma of the 12th thoracic vertebra**

Due to **5516**

Due to _____

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

Major findings: Of operations _____

Of autopsy **See above**

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 **0**

23. Signature **Drury R. Thore** (M. D. or other) _____

Address **Med. Dir. K.C. Gen. Hospital K.C. Mo.**

Duration
Underline the cause to which death should be charged statistically.

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.....

Ray E Snow

Licensed Embalmer No. *25-68*

P. O. Address *1807 E 29th*

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.