

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **9553**

APR 21 1941

Registration District No. **399**

Primary Registration District No. **1002**

Registrar's No. **962**

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

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Kansas City

(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 been dressed
for admittance 15 years (Specify whether years, months or days)

3. (a) PRINT FULL NAME Hefner, George

3. (b) If veteran, name war no

3. (c) Social Security No. 495-09-5585

4. Sex Male

5. Color, or race White

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

6. (b) Name of husband or wife Mrs Cecil Hefner

6. (c) Age of husband or wife if alive 32 years

7. Birth date of deceased. Oct. 9-1906
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>34</u>	<u>4</u>	<u>29</u>	hr. min.

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

10. Usual occupation Senior Decoder

11. Industry or business ✓

MOTHER FATHER

12. Name Leonard Hefner

13. Birthplace Springfield MO
(City, town, or county) (State or foreign country)

14. Maiden name Elizabeth Bink

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

16. (a) Informant Mrs Cecil Hefner

(b) Address 3832 Ashcroft

17. (a) Removal (Burial, cremation, or removal)

(b) Date thereof Mar 10-41
(Month) (Day) (Year)

(c) Place: burial or cremation Mystic, Iowa

18. (a) Signature of funeral director D. Calverly's

(b) Address 6900 Truxtun St. C.M.O.

19. (a) Date received by registrar Mar 9 1941

(b) Registrar's signature M. M. Crowe

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Jackson

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

(d) Street No. 3832 Ashcroft
(If rural, give location)

(e) If foreign born, how long in U. S. A.? Amer 0 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 3-8-41 day 38-41 year 1941 hour 6:45 P. minute 0 M.

21. I hereby certify that I attended the deceased from 6-45 P. to 1941 at 1941 that last saw him alive on 1941 and that he died on the date and hour stated above.

Immediate cause of death

Thrompercardium

Rupture of the aorta

Median cystic aortic aneurysm

Other conditions (include pregnancy within 3 months of death) AI

Major findings:

Of operations 96

Of autopsy 96

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 occupation) _____

Means of injury 3

23. Signature Walter W. Miller (M. D. or other) 2

Address K.C. Mo. Date signed _____

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.....

J. R. Housey

Licensed Embalmer No.....

3682

P. O. Address.....

4042 Baltimore

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.