

Registration District No. 299

Primary Registration District No. 1002

Registrar's No. 1523

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

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Kan City Mo

(c) Name of hospital or institution: 3215 Olive
(If outside city or town limits, write "RURAL" and name of township)

(d) Length of stay: In hospital or institution 5 years
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Magdalen Quint

3. (b) If veteran, name war ✓

3. (c) Social Security No. ✓

4. Sex fe 5. Color or race w

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

6. (b) Name of husband or wife James

6. (c) Age of husband or wife if alive March 9 - 1865 years (Month) (Day) (Year)

8. AGE: Years 76 Months 1 Days 6 If less than one day hr. min.

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

10. Usual occupation Housewife

11. Industry or business same

MOTHER FATHER

12. Name Antone Holzmeister

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

14. Maiden name Therese Anna Kappes

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

16. (a) Informant Mrs Emma Lavener

(b) Address 3215 Olive

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

(b) Date thereof 4/17/41 (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cem

18. (a) Signature of funeral director A. E. Brown

(b) Address 2215 Olive

19. (a) Apr 16, 1941 (Date received local registrar)

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

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. 3215 Olive (If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 15 day April year 1941 hour 10 minute M

21. I hereby certify that I attended the deceased from April 10, 1941, to April 15, 1941

that I last saw h alive on April 10, 1941 and that death occurred on the date and hour stated above.

Immediate cause of death Paralysis

Duration 5 days

Due to Cerebral

Due to Heterorrhage

Other conditions 870

(Include pregnancy within 3 months of death)

Major findings: 870

Of operations 870

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) no

(b) Date of occurrence no

(c) Where did injury occur? no (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? no (Specify type of place) (e) Means of injury no

23. Signature J. F. Mackey (M. D. or other)

Address Kansas City, Mo Date signed

Dr. M...
B...
Pro. 530
11/10

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. 2560

P. O. Address 1807 E 29

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.