

DEC 22 1941 379  
Registration District No.

Primary Registration District No. 1002

1. PLACE OF DEATH:

(a) County Jackson  
(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 No. 1  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 1 Mo. & 1 day  
(Specify whether  
In this community Unknown  
years, months or days)

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. 1424 Summit  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Ralph Oberwetter

3. (b) If veteran, No name war \_\_\_\_\_  
3. (c) Social Security No. 479-07-2340

4. Sex Male 5. Color or race White  
6. (a) Single, widowed, married, divorced Married  
6. (b) Name of husband or wife Mabel Oberwetter  
6. (c) Age of husband or wife if alive 62 years  
7. Birth date of deceased June 14th 1881  
(Month) (Day) (Year)

8. AGE: Years 60 Months 5 Days 0  
If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

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

10. Usual occupation Warehouse

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name Emil Oberwetter  
13. Birthplace Texas  
(City, town, or county) (State or foreign country)  
14. Maiden name Emma Turnbull  
15. Birthplace Minnesota  
(City, town, or county) (State or foreign country)

16. (a) Informant Record Clerk  
(b) Address K.C. Gen. Hospital, K.C. Mo.  
17. (a) ~~Burial~~ Removal (b) Date thereof 11-15-41  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Appleton City, Mo.  
18. (a) Signature of funeral director Frank Lee Funeral Home  
(b) Address Appleton City, Mo.  
19. (a) 11-15-41 (b) M. H. Crowe  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 14th  
year 1941 hour 8 minute 55 P. M.

21. I hereby certify that I attended the deceased from 10-13-41, 19\_\_\_\_ to 11-14-41, 19\_\_\_\_;  
that I last saw him alive on 11-14-41, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

Immediate cause of death  
Luetic aortitis with sacular aneurysm of aorta

Due to 305  
Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations \_\_\_\_\_  
Of autopsy See above

Duration

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) \_\_\_\_\_  
(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? \_\_\_\_\_

(Specify type of place) \_\_\_\_\_  
While at work \_\_\_\_\_ (e) Means of injury 0  
23. Signature Amey R. Thom (M. D. or other) \_\_\_\_\_  
Address Med. dir. K.C. Gen. Hospital Date signed 11-15-41

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

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**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 *Wm. A. Johnson*  
Licensed Embalmer No. *3089*  
P. O. Address *1700*

**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.**