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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_

Registration District No. 379

Primary Registration District No. 1002

Registrar's No. 651

1. PLACE OF DEATH:  
 (a) County Jackson  
 (b) City or town Kansas City Mo.  
(If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
2516 Bales Ave. /  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution None  
(Specify whether  
 In this community 37 Yrs.  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
 (a) State Missouri (b) County Jackson  
 (c) City or town Kansas City Mo.  
(If outside city or town limits, write "RURAL")  
 (d) Street No. 2516 Bales Ave.  
(If rural, give location)  
 (e) If foreign born, how long in U. S. A.? 0 years.

3. (a) PRINT FULLNAME William C. KUHNS

MEDICAL CERTIFICATION

3. (b) If veteran, name war no. 3. (c) Social Security No. 495 01-428

20. DATE OF DEATH: Month 2 day 14 year 42 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_; that I last saw him \_\_\_\_\_, 19\_\_\_\_; and that he died on \_\_\_\_\_, 19\_\_\_\_; and that he died on the date and hour stated above.

6. (b) Name of husband or wife Anna M. Fusselman Kuhns 6. (c) Age of husband or wife if alive 65 years 7. Birth date of deceased February 3rd, 1875  
(Month) (Day) (Year)

Immediate cause of death \_\_\_\_\_

8. AGE: Years 67 Months 0 Days 11 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

Atherosclerosis  
Rupture of the heart  
Acute myocardial infarction  
Chronic coronary occlusion

9. Birthplace Allentown / Pennsylvania  
(City, town, or county) (State or foreign country)

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

10. Usual occupation Clerk - Dept. Mgr.

Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_

11. Industry or business McPike Drug Co.

12. Name William Kuhns.

13. Birthplace \_\_\_\_\_ / Pennsylvania  
(City, town, or county) (State or foreign country)

14. Maiden name Caroline Aker.

15. Birthplace \_\_\_\_\_ / Pennsylvania.  
(City, town, or county) (State or foreign country)

16. (a) Informant Anna M. Fusselman Kuhns.

(b) Address 2516 Bales Ave.

17. (a) Removal (b) Date thereof 2/17/42  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Atchison Kansas.

18. (a) Signature of funeral director Mellody-McGilley.  
K, C. Mo.

(b) Address \_\_\_\_\_

19. (a) 2/16/42 (b) M. M. Browne  
(Date received local registrar) (Registrar's signature)

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? \_\_\_\_\_

While at work? \_\_\_\_\_  
(Specify type of place)  
Means of injury \_\_\_\_\_

23. Signature K. C. Mo (M. D. or other) \_\_\_\_\_  
Address \_\_\_\_\_ Date signed \_\_\_\_\_

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

11

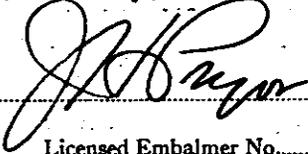
**STATEMENT BY LICENSED EMBALMER**

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. 267

working under my personal supervision.

Signed.....

  
.....  
Licensed Embalmer No. 2999

P. O. Address.....  
CC

**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.**