

No. 2
4-13-40
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DEPARTMENT OF COMMERCE
UNIVERSITY OF THE STATE OF MISSOURI

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

23664

State File No. _____

Registration District No. 399 Primary Registration District No. 1002 Registrar's No. 2676

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: ST. MARY'S HOSP. 0
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 MONTH
(Specify whether In this community 1 mo. years, months or days)

3. (a) PRINT FULL NAME RICHARD WENSTROM
3. (b) If veteran, name war NO 3. (c) Social Security No. 577-03-5514

4. Sex MALE 5. Color or race WH 6. (a) Single, widowed, married, divorced MARRIED
6. (b) Name of husband or wife MINNIE 6. (c) Age of husband or wife if alive 35 years
7. Birth date of deceased FEB. 22, 1900
(Month) (Day) (Year)

8. AGE: Years 42 Months 4 Days 15 If less than one day hr. min.

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

10. Usual occupation ACCOUNTANT

11. Industry or business _____

MOTHER FATHER { 12. Name ISAAC WENSTROM
13. Birthplace NOT KNOWN 9
(City, town, or county) (State or foreign country)
14. Maiden name SYLVIA
15. Birthplace NOT KNOWN 9
(City, town, or county) (State or foreign country)

16. (a) Informant MINNIE WENSTROM
(b) Address NORTH K.C.

17. (a) BURIAL (b) Date thereof 7-13-'42
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation MT. CARMEL CEM.

18. (a) Signature of funeral director J.P. LOUIS FUNERAL HOME
(b) Address KANSAS CITY, MO.

19. (a) 7-13-42 (b) m. m. browne
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State MISSOURI (b) County JACKSON
(c) City or town NORTH KANSAS CITY
(If outside city or town limits, write "RURAL")
(d) Street No. R. R. NO. 10. GREENHAVEN
(If rural, give location)
(e) If foreign born, how long in U. S. A.? N years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 7 day 7
year 42 hour 8:12 minute PM M.

21. I hereby certify that I attended the deceased from Post Mortem Examination, 19____;
that I last saw him alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death Adynamic ileus and Colon following intestinal obstruction (Pneum. interstium). Duration _____
Due to _____

Due to 122 P

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

PHYSICIAN
Major findings: _____
Of operations: _____
Of autopsy: See above
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) (e) Means of injury _____

23. Signature [Signature] (M.D. or other) _____
Address St. Joseph Hospital Kansas Date signed 7/13/42

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

me

561

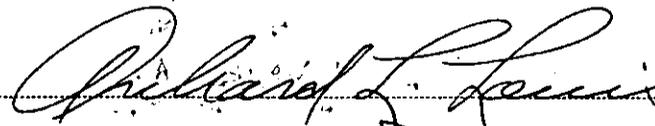
(Licensed Embalmer's Statement on Reverse Side)

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.....



Licensed Embalmer No. 2110

P. O. Address K. C., Mo.

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.