

FILED OCT 5 1942

Registration District No. 149a

Primary Registration District No. 1002

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

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Kennett
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: See Hos #20
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 (Specify whether years, months or days)

In this community 2 (Specify whether years, months or days)

3. (a) PRINT FULL NAME Saw Gasty

3. (b) If veteran, name war Unknown

3. (c) Social Security No. Unknown

4. Sex M 5. Color or race col 6. (a) Single, widowed, married, divorced Unknown

6. (b) Name of husband or wife Unknown 6. (c) Age of husband or wife if alive Unknown years

7. Birth date of deceased Unknown (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

Appr. 55 years of age hr. min.

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

10. Usual occupation Unknown

11. Industry or business Unknown

12. Name Unknown

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

14. Maiden name Unknown

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

16. (a) Informant Record Clerk

(b) Address K.C. General Hosp. #2

17. (a) Anatomical (b) Date thereof 9 23 42 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Western Dental College

18. (a) Signature of funeral director Wellert Funeral Home

(b) Address 2332 Monitor Place : K.C. Mo.

19. (a) 9/23/42 (b) M. M. Brown (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Unknown (b) County Unknown

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

(d) Street No. Unknown (If rural, give location)

(e) Citizen of foreign country? Unknown (Yes or No)

If yes, name country 0

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 9 day 16 year 1942 hour 3 minute 55 P.M.

21. I hereby certify that I attended the deceased from 9-14-42 to 9-16-42 that I last saw him alive on 9-16-42 and that death occurred on the date and hour stated above.

Immediate cause of death Acute Congestive Failure by pneumonia

Due to arteriosclerosis

Other conditions 97

Major findings: Of operations No

Of autopsy No

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 See Hos #2 Date signed 9/21/42

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

Blaine E. Walker

Licensed Embalmer No. *4075*

P. O. Address *2332 Monitor Pl*

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.