

Registration District No. 149

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:  
524 East 15th Street  
(If not in hospital or institution, write street number or location)

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

In this community 12 Years

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. 524 East 15th Street  
(If rural, give location)

(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Kathrine Diefenbach

(b) If veteran, name war No

(c) Social Security No. None

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 12 day 17  
year 1942 hour 7:20 minute a. M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_  
Crown \_\_\_\_\_ 19\_\_\_\_

4. Sex Female / race White

5. Color or / divorced Married

6. (b) Name of husband or wife George Diefenbach

6. (c) Age of husband or wife if alive 63 years

7. Birth date of deceased August 12, 1884  
(Month) (Day) (Year)

that I last saw h. \_\_\_\_\_ alive on \_\_\_\_\_ 19\_\_\_\_  
and that death occurred on the date and hour stated above.

Immediate cause of death Coronary sclerosis  
Chronic fibrous myocarditis  
Acute pulmonary edema

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

8. AGE:	Years	Months	Days	If less than one day
	<u>58</u>	<u>4</u>	<u>5</u>	hr. _____ min.

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

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

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

Of autopsy see above

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

10. Usual occupation Housewife

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

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

12. Name John Cashel

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

14. Maiden name Johanna Sullivan

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

16. (a) Informant Mrs. J. J. Meyer

(b) Address 4033 Brookside Ave

17. (a) Burial (b) Date thereof 12/21/1942  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Floral Hills Cemetery

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? \_\_\_\_\_

18. (a) Signature of funeral director Quirk and Robin

(b) Address 20 West Linwood

19. (a) Dec 21 1942 (b) M. N. Brown  
(Date received local registrar) (Registrar's signature)

White mark? \_\_\_\_\_  
(Specify type of place) (e) Means of injury.

23. Signature [Signature] (M. D. or other) \_\_\_\_\_  
Address R.C. Mo. Date signed 12/17/42

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

MOTHER FATHER

JAN 11 1954

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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.....

Licensed Embalmer No.....

P. O. Address.....

**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.**