

FILED JAN 11 1948
149

Registration District No. _____

Primary Registration District No. **1002**

Registrar's No. **4863**

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 **4 days**
In this community **60 yrs.** (Specify whether 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. **406 Wabash**
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME

Sarah Seeland

3. (b) If veteran, name war _____

3. (c) Social Security No. **None**

4. Sex **Female** 5. Color or race **White**

6. (a) Single, widowed, married, divorced, **widow**

6. (b) Name of husband or wife **No Record**

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

7. Birth date of deceased **April 22 1878**
(Month) (Day) (Year)

8. AGE: Years **64** Months **8** Days **4** If less than one day hr. min.

9. Birthplace **Ill 1**
(City, town, or county) (State or foreign country)

10. Usual occupation **at home**

11. Industry or business _____

MOTHER FATHER

12. Name **No Record**

13. Birthplace **Virginia 1**
(City, town, or county) (State or foreign country)

14. Maiden name **Walther**

15. Birthplace **Virginia 1**
(City, town, or county) (State or foreign country)

16. (a) Informant **Albert W. Fildeter**

(b) Address **4531 Garfield**

17. (a) **Burial** (b) Date thereof **Dec. 29, 1942**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Floral Hill Cem**

18. (a) Signature of funeral director **Mrs. C. R. Gorter**

(b) Address **918 Brooklyn**

19. (a) **12-28-42** (b) **M. M. Crowe**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Dec.** day **26th**
year **1942** hour **6:00 A.** Minute _____ M.

21. I hereby certify that I attended the deceased from **12-22-42** to **12-26-42**, 19____;
that I last saw him/her alive on **12-26-42**, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death _____

CONGESTIVE HEART FAILURE

Due to **43 1/2**

Due to _____

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

Major findings: Of operations _____

Of autopsy **See above**

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 **Dwight R. Hoover** (M. D. or other) _____

Address **Med. Dir. K. C. Gen. Hospital** Date signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

MAY 8 1958

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

Angil C. Browning

Licensed Embalmer No. *2724*

P. O. Address *H. C. ...*

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.