

FILED JAN 21 1943  
Registration District No. \_\_\_\_\_

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

(c) Name of hospital or institution:  
**5001 Indiana**  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **XX**  
**43 years** (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. **5001 Indiana**  
(If rural, give location)

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

3. (a) PRINT FULL NAME **Charles Fredric Laster**

3. (b) If veteran, name war **No**

3. (c) Social Security No. **500-03-1446**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Jan** day **4th**  
year **1943** hour **6:00** minute \_\_\_\_\_ A. M.

4. Sex **Ma**

5. Color or race **Wh**

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

6. (b) Name of husband or wife **Mrs. Linnie Laster**

6. (c) Age of husband or wife if alive **59** years

7. Birth date of deceased: **January 12 1883**  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_;  
**Crowner**  
that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

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

**59 11 22** hr. min.

Immediate cause of death:  
**Chronic fibrous myocarditis**  
**Acute pulmonary edema**

9. Birthplace **Brunswick** No. **0**  
(City, town, or county) (State or foreign country)

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

Due to \_\_\_\_\_ **935**

Other conditions (Include pregnancy within 3 months of death)

10. Usual occupation **Laborer**

11. Industry or business **Goldman Stadium**

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

MOTHER FATHER

12. Name **John Laster**

13. Birthplace **No Record** **9**  
(City, town, or county) (State or foreign country)

14. Maiden name **Fannie Berryhill**

15. Birthplace **No Record** **9**  
(City, town, or county) (State or foreign country)

Of autopsy **See above**

Underline the cause to which death should be charged statistically.

16. (a) Informant **Mrs. Linnie Laster**

(b) Address **5001 Indiana**

17. (a) Burial (b) Date thereof **1-7-43**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Green Lawn 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 **J. Wagner**

(b) Address **Kansas City, Mo.**

19. (a) **1-5-43** (b) **M. M. Crow**  
(Date received local registrar) (Registrar's signature)

While at \_\_\_\_\_ (Specify type of place)

23. Signature **R. C. Mo** **3** (M. D. or other)  
Address \_\_\_\_\_ Date signed **1/4/43**

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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.....

*A. R. Hirschfeld*

Licensed Embalmer No.....

*4159*

P. O. Address.....

*Kansas City 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.**