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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

1253

State File No. _____

409

FILED FEB 10 1943

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. _____

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
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 17 days
In this community 35 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. 2634 Benton (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country.

3. (a) PRINT FULL NAME Francis Nagel

3. (b) If veteran, name war No
3. (c) Social Security No. 495-09-141

4. Sex Male
5. Color or race White
6. (a) Single, widowed, married, divorced Single

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

7. Birth date of deceased April 30, 1877
(Month) (Day) (Year)

8. AGE: Years 65 Months 8 Days 26 15 hr. min.

9. Birthplace New York /
(City, town, or county) (State or foreign country)

10. Usual occupation Tailor

MOTHER FATHER

11. Industry or business
12. Name Lawrence Nagel
13. Birthplace Berlin (City, town, or county) Germany (State or foreign country)
14. Maiden name Lucy Wysocki
15. Birthplace Berlin (City, town, or county) Germany (State or foreign country)

16. (a) Informant Mrs Henry Stein
(b) Address New York

17. (a) Burial (b) Date thereof 1-26-1943
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Floral Hills Cemetery

18. (a) Signature of funeral director
(b) Address 20 West Linwood

19. (a) Jan 26 1943 (b) M. M. Crowe
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 25th
year 1943 hour 1 minute 40 A.M.

21. I hereby certify that I attended the deceased from 1-8-43, 19, to 1-25-43, 19;
that I last saw him alive on 1-25-43, 19;
and that death occurred on the date and hour stated above.

Immediate cause of death
Possible lung abscess-not confirmed by autopsy

Due to
Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy None

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?
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? Means of injury

23. Signature M. M. Crowe (M. D. or other)
Address Dir. Y.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

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.....

Charles M. Quinn

Licensed Embalmer No.....

3774

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.