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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

LED APR 8 1943
149

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

9115

State File No.

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 1530

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:
Kansas City General Hospital No. 1
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 Mo. & 13 days
(Specify whether)

In this community 22 years
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. 920 Wyandotte
(If rural, give location)

(e) Citizen of foreign country? 0 (Yes or No)
If yes, name country.....

3. (a) PRINT FULL NAME Emanuel Hesse

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

3. (c) Social Security No. none

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 Dec. 25th 1879
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>63</u>	<u>6</u>	<u>3</u>	hr. min.

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

10. Usual occupation Real estate

11. Industry or business none

12. Name Henry Hesse

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

14. Maiden name Elizabeth Noll

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

16. (a) Informant Record clerk

(b) Address K.C. General Hospital

17. (a) Removal (b) Date thereof 3-30-43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Memorial Kansas

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

(b) Address Memorial Kansas

19. (a) 3-30-43 (b) M. M. Crowe
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 28th
year 1943 hour 4 minute 20 A. M.

21. I hereby certify that I attended the deceased from 2-15-43, 19... to 3-28-43, 19...
that I last saw him alive on 3-28-43, 19...
and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma of rectum

Due to.....

Due to.....

Other conditions (Include pregnancy within 3 months of death)

PHYSICIAN

Major findings:
Of operations.....

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 Dr. R. J. Shaw (M. D. or other).....
Address Med. Dir. K.C. General Hospital Date signed.....

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

MOTHER FATHER

48110

#HP

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.