V. S. No. 2
50M—5-42
Rev. 5-17-39
I X32873

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAR 31 1943

Registration District No. 199

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 1002

State File No. 9149

Registrar's No. 1413

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: Research Hospital 0
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 10 hours (Specify whether
In this community 24 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 48

(c) City or town Kansas City
(If outside city or town limits, write "RURAL")

(d) Street No. 3332 Summit
(If rural, give location)

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

3. (a) PRINT FULL NAME Mrs. Alice Mae Kashner

3. (b) If veteran, name war xx

3. (c) Social Security No. None

4. Sex Fe

5. Color or race Wh

6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Alonzo R. Kashner

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

7. Birth date of deceased December (Month) 14 (Day) 1865 1855 (Year)

8. AGE: Years 77 87 | Months 3 | Days 7 | If less than one day ..... hr. ..... min.

9. Birthplace Covington (City, town, or county) Ky. 1 (State or foreign country)

10. Usual occupation At Home

11. Industry or business

FATHER
12. Name Samuel Plummer
13. Birthplace No Record (City, town, or county) 9 (State or foreign country)

MOTHER
14. Maiden name Elizabeth Chapman
15. Birthplace (City, town, or county) Ky. 1 (State or foreign country)

16. (a) Informant Mrs. Ruby K. Loring
(b) Address 3332 Summit

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 3/26/1943 (Month) (Day) (Year)
(c) Place: burial or cremation Indianapolis, Ind.

18. (a) Signature of funeral director J W Wagner
(b) Address Kansas City, Mo.

19. (a) 3-23-43 (Date received local registrar) (b) M. M. Crowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 21st
year 1943 hour 3:00 minute A. M.

21. I hereby certify that I attended the deceased from Mar. 19
Mar 19, 1943, to Mar 20, 1943
that I last saw her alive on Mar 19, 1943
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Pneumonia Right Bronchial	
Due to Fall in Home Mar 18 Resulting in Fracture of Superchondr	1943
Due to Diabetes	
Other conditions (Include pregnancy within 3 months of death) 1865	
Major findings: Of operations 18	
Of autopsy none	

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) Acc 123

(b) Date of occurrence March 18 1943

(c) Where did injury occur? K.C. (City or town) Jackson (County) Mo (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
Home (Specify type of place)
While at work? (e) Means of injury Fall

23. Signature A. O. Kuhn M.D. (M. D. or other)
Address Rialto B Date signed 3-23-43

(Licensed Embalmer's Statement on Reverse Side)

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. Hainschild

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.