

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

X3287

Registration District No. 1948/149

Primary Registration District No. 1002

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 11 days
(Specify whether years, months or days)
 In this community unknown

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. 1525 Main St
(If rural, give location)
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME John F. Stratmier

3. (b) If veteran, name war no 3. (c) Social Security No. none

4. Sex Male 5. Color or race W. 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 March 21st 1885
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
57-58 11 22 23 hr. min.

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

10. Usual occupation Gardener

11. Industry or business none

MOTHER FATHER { 12. Name Wm. Stratmier

13. Birthplace no record 9
(City, town, or county) (State or foreign country)

14. Maiden name Roseila Cook

15. Birthplace no record 9
(City, town, or county) (State or foreign country)

16. (a) Informant Record clerk

(b) Address K.C. General Hospital

17. (a) K.C. Western Dental College (b) Date thereof 3/23/43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation K.C. Western Dental College

18. (a) Signature of funeral director James - Mayberry

(b) Address Linwood at D. like

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 14th
 year 1943 hour 10 minute 33 P. M.

21. I hereby certify that I attended the deceased from 3-3-43 19... to 3-14-43 19...
 that I last saw h. im alive on 3-14-43 19...
 and that death occurred on the date and hour stated above.

Immediate cause of death Asthma
 Duration _____

Due to 11a

Due to _____

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

Major findings: Of operations _____
 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) _____
 (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 Dwight R. Shorn (M.D. or other) _____
 Address Med. Dir. K.C. General Hospital Date signed _____

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.....

Roy E Snow

Licensed Embalmer No.....

2560

P. O. Address.....

14c 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.