

Registration District No. **149**

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: 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 5 days
(Specify whether)
 In this community Since 1906
years, months or days

3. (a) PRINT FULL NAME Emile Hullebusch
3. (b) If veteran, name war no
3. (c) Social Security No. 48-86-10-4000
4. Sex Male **5. Color or** wh **6. (a) Single, widowed, married,** Married
race **6. (b) Name of husband or wife** Martha **6. (c) Age of husband or wife if** 53
divorced **7. Birth date of deceased** Oct 11 - 1885
(Month) (Day) (Year)

8. AGE: Years 57 Months 5 Days 29
 If less than one day hr. min.

9. Birthplace Belgium **4**
(City, town, or county) (State or foreign country)

10. Usual occupation Railroad

11. Industry or business Brown

12. Name Brown

13. Birthplace Belgium **4**
(City, town, or county) (State or foreign country)

14. Maiden name Unknown

15. Birthplace Unknown **9**
(City, town, or county) (State or foreign country)

16. (a) Informant Emile Hullebusch

(b) Address 3529 Nicholson

17. (a) Burial **(b) Date thereof** 4-13-43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Mary's Cem

18. (a) Signature of funeral director Ketter

(b) Address 2657 Grand Ave

19. (a) 4/13/43 **(b) M. M. Brown**
(Date received local registrar) (Registrar's signature)

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. 3557 Nicholson
(If rural, give location)
 (e) Citizen of foreign country? No
If yes, name country

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month April day 10th
 year 1943 hour 6 minute 45 P. M.
21. I hereby certify that I attended the deceased from 4-5-43 1943 to 4-10-43 1943
 that I last saw him alive on 4-10-43 1943
 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral hemorrhage

Due to 83

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings:
 Of operations
 Of autopsy See above

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)
 (c) Means of injury
23. Signature Dr. R. J. Thomas (M. D. or other)
 Address Med. Dir. K.C. Gen. Hospital Date signed

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

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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.....

F. S. Walton

Licensed Embalmer No. *2744*

P. O. Address *3030 Harrison*

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.