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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

Registrar's No. 3594

LED AUG 27 1943
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:
5818 McGee Street, /
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution no (Specify whether years, months or days)

In this community 60 years, (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED: 48

(a) State Missouri (b) County Jackson

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

(d) Street No. 5818 McGee Street
(If rural, give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country x

3. (a) PRINT FULL NAME Mrs. Laura L. Hagenbuch

3. (b) If veteran, name war no

3. (c) Social Security No. no

4. Sex Female

5. Color or race White

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

6. (b) Name of husband or wife George W. Hagenbuch

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

7. Birth date of deceased August 30 1862
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 19th
year 1943 hour 3:20 minute 8 A. M.

21. I hereby certify that I attended the deceased from Aug 4, 1943, to Aug 19, 1943, that I last saw him alive on Aug 18, 1943, and that death occurred on the date and hour stated above.

8. AGE:	Years	Months	Days	If less than one day
	<u>80</u>	<u>11</u>	<u>20/19</u>	hr. min.

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

10. Usual occupation at home

Immediate cause of death Myocardial failure and Broncho pneumonia 6 hrs
Duration

Due to _____

Due to _____

Other conditions Myocardial failure
(Include pregnancy within 3 months of death)

Chronic Hypertension

11. Industry or business x

12. Name Charles Genung

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

14. Maiden name Laura Luella

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

16. (a) Informant Charles W. Hagenbuch,

(b) Address 5818 McGee, Kansas City, Mo.

17. (a) Burial (b) Date thereof 8-21-43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Forest Hill Cemetery

18. (a) Signature of funeral director Stine & McClure,

(b) Address 3235 Gillham Plaza, Kansas City, Mo.

19. (a) 8-20-43 (b) P. C. Brown
(Date received local registrar) (Registrar's signature)

Major findings: Of operations none

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? _____
(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)

Means of injury _____

23. Signature Thomas J. Brown (M. D. or other) _____

Address Brown, 1st, Mo Date signed 2/19/43

PHYSICIAN

Underline the cause to which death should be charged statistically.

Dr. Harry Jones
Bryant - Body
No. 0848

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.

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THE STATE BOARD OF HEALTH OF MISSOURI
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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: _____

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____
(Specify whether years, months or days)

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

3. (a) PRINT FULL NAME Laura L. Hagenbuch

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex F

5. Color or race W

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

6. (b) Name of husband or wife _____

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

7. Birth date of deceased Aug 30
(Month) (Day) (Year)

8. AGE: Years 80 Months 11 Days _____
(If less than one day, in min.)

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

10. Usual occupation _____

11. Industry or business _____

12. Name _____

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

14. Maiden name _____

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

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____
(Data received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____

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

(d) Street No. _____
(If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 9 year 1943 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19____; that I last saw him/her alive on _____ 19____; and that death occurred on the date and hour stated above.

Immediate cause of death Wemic coma & Bronchopneumonia today Duration _____

Due to Chronic nephritis years _____

Due to _____

Other conditions myocardial failure
(Include pregnancy within 3 months of death)

Major findings: chronic hypertension

Of operations _____

Of autopsy 1318

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) _____ (Means of injury)

23. Signature Harry L. Fould (M. D. or other) _____

Address Kansas City, Mo Date signed 9-4-43

SUPPLEMENTARY

FILED SEP 7 1948
SEP 7 1948

FILED SEP 7 1948
SEP 7 1948

27328