

No. 2
4-2-43
5-17-39
X35697

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

30900

FILED OCT 13 1943

State File No. _____

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 4113

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 22 days
(Specify whether)

In this community 29 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. 2509 Troost Avenue
(If rural, give location)

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

3. (a) PRINT FULL NAME Belle Melissa Pfliegier

3. (b) If veteran, name war No

3. (c) Social Security No. None

4. Sex Female

5. Color or race White

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

6. (b) Name of husband or wife Mr. William T. Pfliegier

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

7. Birth date of deceased September 22 1865
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

78 0 2 _____ hr. _____ min.

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

10. Usual occupation Pantry Girl - Retired

11. Industry or business Kansas City Club

MOTHER FATHER {

12. Name Unknown Hawley

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

14. Maiden name Unknown

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

16. (a) Informant Miss Lillian Pfliegier

(b) Address 2509 Troost Avenue

17. (a) Burial (b) Date thereof Sept. 27, 1943
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Green Lawn Cemetery

18. (a) Signature of funeral director D. H. Newcomer, Done

(b) Address 1401 Brush Creek Blvd.

19. (a) 9-28-43 (b) J. E. Brown, WEP
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 24th
year 1943 hour 6 minute _____ A.M.

21. I hereby certify that I attended the deceased from Sept. 2nd, 1943 to Sept. 24th, 1943
that I last saw her alive on Sept. 24th, 1943
and that death occurred on the date and hour stated above.

Immediate cause of death Leukemia (type undetermined)
Duration _____

Due to _____

Due to _____

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

PHYSICIAN

Major findings: _____
Of operations _____

Of autopsy _____

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 D. R. Shaw (M. D. or other) _____
Address Gen'l Hosp. Med. Dir. Date signed 9-24-43

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

751

(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. C. Tivromer*

Licensed Embalmer No. 4043

P. O. Address K. C. 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.