

FILED FEB 28 1944

Registration District No. 149

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 1002

State File No. 1397

Registrar's No. 72

1. PLACE OF DEATH: Jackson
 (a) County Kansas City
 (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
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 2 days (Specify whether
 In this community 58 years years, months or days)

3. (a) PRINT FULL NAME Carl F. Gehring
 3. (b) If veteran, name war No
 3. (c) Social Security No. 486-05-8095

4. Sex Ma 5. Color or race Wh
 6. (a) Single, widowed, married, divorced Widowed
 6. (b) Name of husband or wife Lula M. Gehring
 6. (c) Age of husband or wife if alive XX years
 7. Birth date of deceased: June 24 1873
 (Month) (Day) (Year)

8. AGE: Years 70 Months 6 Days 11
 If less than one day hr. min.

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

10. Usual occupation Retired Foreman
Blue Line Transfer

11. Industry or business Fredrick Gehring

12. Name Fredrick Gehring

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

14. Maiden name Katherine Mai

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

16. (a) Informant Miss Lillian Gehring
 (b) Address 1907 Broadway

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-8-44
 (Month) (Day) (Year)
 (c) Place: burial or cremation Mt. Washington

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

19. (a) Jan. 1944 (Date received local registrar) (b) J.E. Brown (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. 1907 Broadway
 (If rural, give location)
 (e) Citizen of foreign country? No (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month Jan. day 5
 year 1944 hour 4: minute 40 A. M.

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

Immediate cause of death uremia
Nephritis, bilateral
Prostatic Abscess.
 Due to _____
 Due to _____

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations 133a
 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 W.E. Wagner (M. D. or other) M.D.
 Address 25 M. Way Date signed 1/5/44

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. *4659*

P. O. Address *R. O. 1 W*

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.