

FILED FEB 10 1944

State File No. _____

325

Registration District No. 1799

Primary Registration District No. 1002

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Jackson
 (b) City or town Kansas
 ((If outside city or town limits, write "RURAL" and name of township))
 (c) Name of hospital or institution:
Gardner & Milwaukee Crossing (Boxcar)
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____ (Specify whether
 In this community Do not Know years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Jackson
 (c) City or town Kansas City Mo
 ((If outside city or town limits, write "RURAL")
 (d) Street No. Gardner & Milwaukee Crossing
 ((If rural, give location)
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME Ignatz Kupina

3. (b) If veteran, name was Do not Know 3. (c) Social Security No. Do not Know

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Do not Know

6. (b) Name of husband or wife Do not Know 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Unknown 1890
 (Month) (Day) (Year)

8. AGE: Years 54 Months — Days — If less than one day _____ hr. _____ min.

9. Birthplace Do not Know 9
 (City, town, or county) (State or foreign country)

10. Usual occupation Do not Know

11. Industry or business _____

MOTHER FATHER { 12. Name Do not Know

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

14. Maiden name Do not Know

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

16. (a) Informant Coroner Office

(b) Address Kansas City Mo

17. (a) Removed (b) Date thereof Jan 19-44
 (Burial, cremation, or removal) (Month) (Day) (Year)

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

18. (a) Signature of funeral director Passantino Bros

(b) Address Kansas City Mo

19. (a) Jan 20 1944 (b) J. E. Brewer
 (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 18
 year 1944 hour 2 minute 30 a. M.

21. I hereby certify that I attended the deceased from Deputy 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 Arteriosclerotic Heart Disease
 Due to _____
 Due to _____

Other conditions (Include pregnancy within 3 months of death)

PHYSICIAN _____
 Major findings: _____
 Of operations 93d
 Of autopsy Inspection 9
History

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)
 23. Signature J. E. Brewer _____ (M. D. or other)
J. E. Brewer _____
 Address 22 McCoy Date signed 1/20/44

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..... *Patrick M. Rowe*

Licensed Embalmer No. *2347*

P. O. Address..... *I. C. 700*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.