

FILED JAN 10 1944

State File No. \_\_\_\_\_

5578

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County Jackson  
(b) City or town Law  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: St. Luke's Hosp.  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 20 days  
(Specify whether  
In this community 20 days  
years, months or days)

3. (a) PRINT FULL NAME Elmer V. List

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. NO

4. Sex Male 5. Color or race W  
6. (a) Single, widowed, married, divorced Married  
6. (b) Name of husband or wife Ruth 6. (c) Age of husband or wife if alive 46 years  
7. Birth date of deceased Feb 22, 1894  
(Month) (Day) (Year)

8. AGE: Years 49 Months 10 Days 5 If less than one day hr. \_\_\_\_\_ min.

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

10. Usual occupation farmer

11. Industry or business \_\_\_\_\_

MOTHER FATHER {  
12. Name Benj. List  
13. Birthplace unknown  
(City, town, or county) (State or foreign country)  
14. Maiden name Anna  
15. Birthplace unknown  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Ruth List  
(b) Address Garnett, Kans  
17. (a) Removal (b) Date thereof 12/27/43  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Garnett, Kans

18. (a) Signature of funeral director Stine-McClure

(b) Address Kansas City, MO

19. (a) 12-28-43 (b) P.C. Brown  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Kansas (b) County 999  
(c) City or town Garnett, Kans  
(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 31

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 12 day 27  
year 1943 hour 12 minute 25 A.M.

21. I hereby certify that I attended the deceased from 12/8  
1943, to 12/27, 1943;  
that I last saw him alive on 12/27/43, 1943,  
and that death occurred on the date and hour stated above.

Immediate cause of death Acute Glomerulonephritis  
Duration \_\_\_\_\_

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions Chronic Hypertension 2400  
(Include pregnancy within 3 months of death) Cardiac Hypertrophy

Major findings: \_\_\_\_\_ PHYSICIAN  
Of operations \_\_\_\_\_

Of autopsy Same as above.  
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) (e) Means of injury \_\_\_\_\_

23. Signature P.T. Bohan (M.D. or other)  
Address Boyan Med Bldg, City, Kans Date signed 12/27/43

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

2.25 J. M.  
W. A. M. G. B. B. B.

**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 John A. Huley  
Licensed Embalmer No. 458  
P. O. Address Kansas City

**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.**

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. Feb  
Registrar's No. 5578

Registration District No. 149 Primary Registration District No. 1002

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

3. (a) PRINT FULL NAME Elmer V. List

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced \_\_\_\_\_

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_

7. Birth date of deceased Feb. 22 1899  
(Month) (Day) (Year)

8. AGE: Years 49 Months 10 Days \_\_\_\_\_ If less than one day \_\_\_\_\_ min.

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

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 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) \_\_\_\_\_  
(Date 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 Feb Day 27  
year 1943 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

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

Immediate cause of death acute hemorrhagic hepatitis Duration 3 mos

Due to Chronic glomerulonephritis, 10 yrs

Due to Infected Teeth + gum abscess

Other conditions arterial hypertension  
(Include pregnancy within 3 months of death)

Major findings: Cardiac hypertrophy  
Of operations \_\_\_\_\_

Of autopsy Same as above.  
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) (e) Means of injury \_\_\_\_\_

23. Signature Arnold V. Armstrong (M. D. or other) \_\_\_\_\_  
Address Plaza Med Bldg Date signed 2/27/44  
St. Louis, Mo

SUPPLEMENTARY

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

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