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7-39  
K35927

**FILED JAN 10 1944**  
Registration District No. **249**

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: **Lakeside Hospital**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: **10 days** in hospital or institution (Specify whether  
In this community **55 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. **1625 Madison**  
(If rural, give location)  
(e) Citizen of foreign country? **No** (Yes or No)  
If yes, name country **1**

3. (a) PRINT MRS. AMELIA WARMHOLZ  
FULL NAME

3. (b) If veteran, name war **XX** 3. (c) Social Security No. **No**

4. Sex **Fe** 5. Color or race **Wh** 6. (a) Single, widowed, married, divorced **Widowed**

6. (b) Name of husband or wife **William Warmholz** 6. (c) Age of husband or wife if alive **XX** years

7. Birth date of deceased **May 14 1860**  
(Month) (Day) (Year)

8. AGE: Years **83** Months **7** Days **15** If less than one day hr. min.

9. Birthplace **Buffalo N.Y.**  
(City, town, or county) (State or foreign country)

10. Usual occupation **At Home**

11. Industry or business

12. Name **Jacob Mohrs**

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

14. Maiden name **No Record**

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

16. (a) Informant **William Warmholz**

(b) Address **1625 Madison**

17. (a) **Burial** (Burial, cremation, or removal) (b) Date thereof **12-31-43**  
(Month) (Day) (Year)

(c) Place: burial or cremation **Mt. Washington**

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

19. (a) **Dec 30 1943** (Date received local registrar) (b) **J.B. Brown** (Registrar's signature)

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month **Dec.** day **29th**  
year **1943** hour **11:** minute **10 A.** M.

21. I hereby certify that I attended the deceased from **Dec. 20 - 1943** to **Dec. 29 - 1943**  
that I last saw her alive on **Dec. 29 - 1943**  
and that death occurred on the date and hour stated above.

Immediate cause of death **Cerebral Hemorrhage** Duration **10 days**  
Due to **Arterio-Sclerosis & 30' Hypertension** yrs.

Other conditions **Hypertensive Hemorrhage - bi-lateral** yrs.

PHYSICIAN  
Major findings:  
Of operations  
Of autopsy

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 **G. J. Schindler** (M. D. or other) **P.O.**  
Address **4-21 Schubert Bldg.** Date signed **12/30-43**

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

MOTHER FATHER

Shubert Bg  
1115 Grand

**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. R. Harnscheidt  
Licensed Embalmer No. 4159  
P. O. Address Kansas city 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.**