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

FILED FEB 20 1944

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

Registration District No. 107

Primary Registration District No. 1002

Registrar's No. 431

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: 1615 Chelsea 1  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether  
in this community: 9 months 15 Days 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. 1615 Chelsea  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME

Asa Demas Weston

3. (b) If veteran, name war no

3. (c) Social Security No. no

4. Sex M 5. Color or race wh 6. (a) Single, widowed, married, divorced single

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

7. Birth date of deceased Apr 8 1943  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
9 15 hr. min.

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

10. Usual occupation Child

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

12. Name Emanuel Weston

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

14. Maiden name Demas M. Carter

15. Birthplace St Louis MO  
(City, town, or county) (State or foreign country)

16. (a) Informant M. Emanuel Weston

(b) Address 1615 Chelsea

17. (a) Burial (b) Date thereof 1-25-44  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Fun Home

18. (a) Signature of funeral director Mrs. P. J. Forster

(b) Address St. Louis

19. (a) Jan 25, 1944 (b) J. B. Brown  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month JAN 23rd  
year 1944 hour 11.05 minute \_\_\_\_\_ P. M.

21. I hereby certify that I attended the deceased from JAN 21  
1944 to JAN 23, 1944  
that I last saw him alive on JAN 22, 1944  
and that death occurred on the date and hour stated above.

Immediate cause of death Bronchial Pneumonia

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

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

Other conditions No Contagion  
(Include pregnancy within 3 months of death)

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

Of autopsy 109

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 injury) \_\_\_\_\_ (Means of injury)

23. Signature John E. Caranough (M.D. or other) \_\_\_\_\_

Address 4901 E. 27th St. Date signed 1/23/44

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

**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

*Sharon A. Redmon*

Licensed Embalmer No. *2737*

P. O. Address *Home*

**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.**