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35897

FILED JAN 19 1944

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

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 5702

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:  
Trinity Lutheran Hosp  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 Week  
(Specify whether years, months or days)

In this community 23 yrs  
(Specify whether 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. 609 West 75th  
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)  
If yes, name country 0

3. (a) PRINT FULL NAME Evaline B. Wheeler

3. (b) If veteran, name war no

3. (c) Social Security No. none

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

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

7. Birth date of deceased Jan. 11/1862  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

81 11 18 hr. min.

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

10. Usual occupation Housewife

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

MOTHER FATHER { 12. Name Geo. C. Babcock

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

14. Maiden name Evelyn Hastings

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

16. (a) Informant Mary B. Sayers

(b) Address 609 West 75th

17. (a) Mt. Moriah Burial (b) Date thereof Jan. 3rd 1944  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Moriah Cemetery

18. (a) Signature of funeral director Harold Rose

(b) Address 7406 Wornall Rd

19. (a) Dec 31-1943 (b) John Brown  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 12 day 29  
year 1943 hour 2 minute 0 A. M.

21. I hereby certify that I attended the deceased from Dec 19 1943, to Dec 28 1943  
that I last saw him alive on Dec 28 1943  
and that death occurred on the date and hour stated above.

Immediate cause of death Bronchopneumonia 6 days

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

Due to 101

Other conditions Chronic Bronchitis two year  
(Include pregnancy within 3 months of death)

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

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 R. C. Pagan (M. D. or other) \_\_\_\_\_

Address 404 1/2 W 75th Date signed 12.30.43

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

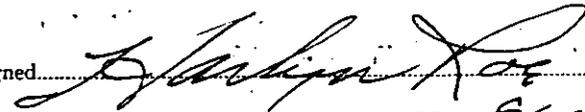
**STATEMENT BY LICENSED EMBALMER**

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.....

2810

P. O. Address.....

Kemo

**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..**