

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **6175**
Registrar's No. **564**

FILED FEB 18 1944
Registration District No. **1002**

Primary Registration District No. **1002**

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

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:
528 Bales
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution.....
In this community..... 32 Years (Specify whether years, months or days)

3. (a) PRINT FULL NAME VERD EMMET KUHN

3. (b) If veteran, name war. No

3. (c) Social Security No. None

4. Sex Male

5. Color or Race White

6. (a) Single, widowed, married, divorced. Single

6. (b) Name of husband or wife.....

6. (c) Age of husband or wife if alive..... years

7. Birth date of deceased Nov. 4, 1906
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>37</u>	<u>2</u>	<u>28</u>	hr. _____ min.

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

10. Usual occupation Novelty Worker

11. Industry or business.....

12. Name John C. Kuhn

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

14. Maiden name Stella Hays

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

16. (a) Informant John C. Kuhn

(b) Address 528 Bales

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-4-44
(Month) (Day) (Year)

(c) Place: burial or cremation Memorial Park Cemetery

18. (a) Signature of funeral director G. H. Bleckman & Son, Inc.

(b) Address Kansas City, Mo.

19. (a) 2-3-1944 (Date received local registrar) (b) T. E. Brown (Registrar's signature)

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. 528 Bales
(If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 2
year 1944 hour 3 minute 30 A. M.

21. I hereby certify that I attended the deceased from 1942, to Feb 2 1944
that I last saw him alive on Feb 1 1944
and that death occurred on the date and hour stated above.

Immediate cause of death Intestinal tuberculosis

Duration 2 yrs

Due to.....

Due to.....

Other conditions Epilepsy
(Include pregnancy within 3 months of death)

Major findings:
Of operations.....

Of autopsy None

PHYSICIAN 15

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)

(c) Means of injury.....

23. Signature E. W. Slusher (M. D. or other)

Address 900 Rialto Bldg K C Mo Date signed 2-5-44

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.....

Licensed Embalmer No.....

P. O. Address.....

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.