

FILED MAR 6 1944
Registration District No. **146**Primary Registration District No. **5568**Registrar's No. **34**

1. PLACE OF DEATH:

(a) County **Jackson**
 (b) City or town **Kansas City Intercity Dist.**
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
8715 Roberts Blue Twp.
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
 (Specify whether _____)
 In this community **53** years
 (years, months or days)

8. (a) PRINT FULL NAME **Tony Weaver (Anton Vavrusa)**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 **Widowed**

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

7. Birth date of deceased **June 24, 1861**
(Month) (Day) (Year)8. AGE: Years Months Days If less than one day
82 **7** **17** _____ hr. _____ min.9. Birthplace **Austria** 4
(City, town, or county) (State or foreign country)10. Usual occupation **Car Repair man (retired)**11. Industry or business **Armours**12. Name **Anton Vavrusa**18. Birthplace **Austria** 4
(City, town, or county) (State or foreign country)14. Maiden name **Anna Unknown**15. Birthplace **Austria** 4
(City, town, or county) (State or foreign country)16. (a) Informant's own signature **Mrs. Anna Edgerton**(b) Address **8715 Roberts**17. (a) **Burial** (b) Date thereof **2-12-44**
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation **Mount Hope**(a) Signature of funeral director **Edna Buss**(b) Address **1416 Minnesota**19. (a) **2-12-1944** (b) **J. J. [Signature]**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Jackson** 48
 (c) City or town **Kansas City Intercity Dist.**
 (If outside city or town limits, write "RURAL")
 (d) Street No. **8715 Roberts Blue Twp.**
 (If rural, give location)
 (e) If foreign born, how long in U. S. A. **53** years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **February** day **10**
year **1944** hour **6:40** A. M. minute _____ M.21. I hereby certify that I attended the deceased from **2/4**
2/4, 19**44** to **2/8**, 19**44**
that I last saw him alive on **2/8**, 19**44**
and that death occurred on the date and hour stated above.

Immediate cause of death

Lobar pneumonia 5 days

Due to _____

Due to _____

Other conditions **Hip fracture 12/28/43**
(Include pregnancy within 3 months of death)Major findings:
Of operations _____

Of autopsy _____

22. If death was due to external causes, fill in the following: 048

(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?
(Specify, type of place) _____

While at work? _____ (e) Means of injury _____

23. Signature **R. J. [Signature]** (M. D. or other) _____Address **5400 St. John Ave.** Date signed **2/11/44**

531 E. College
Pass.

MAR 8 194

MAR 6 194

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 O. H. Beckwith

Licensed Embalmer No. 3937

P. O. Address Kansas City Kansas

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, above space should be left blank.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. March
Registrar's No. 34

Registration District No. 146 Primary Registration District No. 5568

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

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Blue Springs
(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 _____ (Specify whether)
years, months or days

3. (a) PRINT FULL NAME

Jerry Weaver

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 W

6. (b) Name of husband or wife _____

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

7. Birth date of deceased

June 24 1886
(Month) (Day) (Year)

8. AGE:

Years 82

Months 7

Days _____

If less than one day _____ min.

9. Birthplace

(City, town, or county)

Indiana
(State or foreign country)

10. Usual occupation

11. Industry or business

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)

(Burial, cremation, or removal)

(b) Date thereof

(Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a)

(Date received local registrar)

(b)

(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 _____ year 1944 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 stroke pneumonia

Duration

Due to _____

Due to _____

Other conditions Hip fracture 7/28/43
(Include pregnancy within 3 months of death)

ADDITIONAL PHYSICIAN
Major findings: 1860
Of operations: SUPPLEMENTARY
Of autopsy: REQUEST

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) Accident

(b) Date of occurrence 12/28-43

(c) Where did injury occur? Parol Jackson Co. MO
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
On premises at home fall

While at work? no (Specify type of place)
(e) Means of injury _____

23. Signature: P. Williams (M. D. or other)

Address _____ Date signed _____

SUPPLEMENTARY

7376