

Registration District No. **149**

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: **Robinson's Clinic**
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution **7 days**
 In this community **57 years**
 (Specify whether 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. **4914 Brookside Blvd.**
 (If rural, give location)
 (e) Citizen of foreign country? **no** (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME **GEORGE A. GUNZ.**
 (b) If veteran, name war **no**
 (c) Social Security No. **none**

4. Sex **Male** 5. Color or race **White** 6. (a) Single, widowed, married, divorced, **widower**
 (b) Name of husband or wife **Olga Gunz** 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased **September 16, 1868**
 (Month) (Day) (Year)

8. AGE: Years **75** Months **4** Days **22** If less than one day
 hr. **21** min. _____

9. Birthplace **Oshkosh, Wisconsin**
 (City, town, or county) (State or foreign country)

10. Usual occupation **Retired**

11. Industry or business **Oil**

MOTHER FATHER { 12. Name **John G. Gunz**
 13. Birthplace **Germany**
 (City, town, or county) (State or foreign country)
 14. Maiden name **Unknown**
 15. Birthplace **Germany**
 (City, town, or county) (State or foreign country)

16. (a) Informant **Dr. George E. Gunz**

(b) Address **4914 Brookside Blvd.**

17. (a) **Burial** (b) Date thereof **4-10-44**
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Burial Int Memorial**

18. (a) Signature of funeral director **Freeman Mortuary**

(b) Address **104 west 42nd st.**

19. (a) **4-8-44** (b) **T. E. Brown**
 (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month **April** - day **7**
 year **1944** hour **10** minute **30 P.M.**

21. I hereby certify that I attended the deceased from **March 31**
 19 **44** to **April 7** 19 **44**
 that I last saw him alive on **April 7** 19 **44**
 and that death occurred on the date and hour stated above.

Immediate cause of death **Had Tumor of Prostate gland & Prostatectomy of Blood**
 Due to **Probably, Poisoning**

Due to _____

Other conditions **Toxic Delirium**
 (Include pregnancy within 3 months of death)

Major findings:
 Of operations _____
 Of autopsy _____

PHYSICIAN
 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)
 (a) Means of injury _____

23. Signature **W. E. Whelan** (M. D. or other) _____

Address **2625 Paseo** Date signed **4-8-44**

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.