

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: K. C. General Hospital No. 1  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 1 mo. 2 days  
(Specify whether  
In this community unknown  
years, months or days)

3. (a) PRINT FULL NAME Charles Sovern

3. (b) If veteran, name war no 3. (c) Social Security No. none

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

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

7. Birth date of deceased unknown  
(Month) (Day) (Year)

8. AGE: Years 72 Months Days If less than one day  
hr. min.

9. Birthplace no record 9  
(City, town, or county) (State or foreign country)

10. Usual occupation

11. Industry or business

12. Name parents

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

14. Maiden name 9

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

16. (a) Informant ICC General Hospital

(b) Address ICC mo.

17. (a) (Burial, cremation, or removal) (b) Date thereof 3/27/44  
(Month) (Day) (Year)

(c) Place: burial or cremation ICC Outpatient College

18. (a) Signature of funeral director same as member

(b) Address same as member

19. (a) 3-28-44 (b) D. C. Brown  
(Date received local registrar) (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. 1012 E. 15 St.  
(If rural, give location)  
(e) Citizen of foreign country? no (Yes or No)  
If yes, name country no

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 18  
year 1944 hour 3 minute 20 A. M.

21. I hereby certify that I attended the deceased from February 16, 1944, to March 18, 1944,  
that I last saw him alive on March 18, 1944,  
and that death occurred on the date and hour stated above.

Immediate cause of death Bronchopneumonia

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

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

Other conditions (include pregnancy within 3 months of death)

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

Of autopsy 107

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 2  
(M. D. or other) D.M.D.

23. Signature A. E. Walker Date signed 3-18-44  
Address 212 M. Ave

Duration  
PHYSICIAN  
Underline the cause to which death should be charged statistically.

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.....

*Roy E. Snow*

Licensed Embalmer No. *2566*

P. O. Address: *K. Mo*

**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.**