

FILED MAY 11 1944 49

Registration District No. ....

Primary Registration District No. 1002

Registrar's No. ....

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

1. PLACE OF DEATH:

(a) County JACKSON

(b) City or town KANSAS CITY, MO.  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: FAIRMOUNT HOSPITAL  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 9 DA. (Specify whether years, months or days)

In this community 9 DA.

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. 1414 E. 27  
(If rural, give location)

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

3. (a) PRINT FULL NAME WALTER MELNYK

3. (b) If veteran, name war X no

3. (c) Social Security No. none

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month APRIL day 23  
year 1944 hour 9 minute 45 P.M.

4. Sex MALE 5. Color or race WHITE 6. (a) Single, widowed, married, divorced, SINGLE

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

7. Birth date of deceased: APRIL 15 1944  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from APR. 15 1944 to APR. 23 1944;  
that I last saw him alive on APRIL 23 1944;  
and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day  
0 0 8 ✓ hr. ✓ min.

Immediate cause of death congenital heart

Due to .....

Due to .....

9. Birthplace KANSAS CITY, MO.  
(City, town, or county) (State or foreign country)

10. Usual occupation infant

11. Industry or business

Other conditions (Include pregnancy within 3 months of death)

Major findings:  
Of operations 1572

Of autopsy

MOTHER FATHER

12. Name WALTER VANDEMARK

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

14. Maiden name LEE MELNYK

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

PHYSICIAN

Underline the cause to which death should be charged statistically.

16. (a) Informant FAIRMOUNT HOSPITAL

(b) Address 1414 E 27 - K.C. MO.

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

(c) Place: burial or cremation Green Lawn

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? .....

(d) Did injury occur in or about home, on farm, in industrial place, in public place? .....

18. (a) Signature of funeral director A. P. Dochter

(b) Address 1415 East 15

19. (a) 5-1-44 (b) T. E. Brown  
(Date received local registrar) (Registrar's signature)

While at work? .....

(Specify type of place) (c) Means of injury 0

23. Signature Fred Stinger (M. D. or other)

Address 510 Prof. Bldg Date signed 4-24-44

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**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.**