

FILED JUN 3 1944

Registration District No. 17 Primary Registration District No. 1002

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: ST. MARYS HOSPITAL  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 1-DAY (Specify whether years, months or days) 45 YEARS

3. (a) PRINT FULL NAME MR. FRANK MERRIAM BLOOMHUFF

3. (b) If veteran, name war No 3. (c) Social Security No. 702-14-5363

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

6. (b) Name of husband or wife MRS. EVAM. BLOOMHUFF 6. (c) Age of husband or wife if alive 71 years

7. Birth date of deceased JUNE 10 1875  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>68</u>	<u>11</u>	<u>14</u>	hr. _____ min.

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

10. Usual occupation RETIRED SPECIAL OFFICER

11. Industry or business MISSOURI PACIFIC R.R.

12. Name FRANK BLOOMHUFF

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

14. Maiden name MARY CATHERINE HEIDRICK  
(City, town, or county) (State or foreign country)

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

16. (a) Informant Mrs. H.R. Engle

(b) Address 4033 Main St

17. (a) BURIAL (b) Date thereof MAY 26 1944  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation GREEN LAWN CEM.

18. (a) Signature of funeral director D. H. Newcomer's Sons

(b) Address 1401 BRUSH CREEK BLVD.

19. (a) 5-25-44 (b) D. E. 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 8  
(If outside city or town limits, write "RURAL")  
(d) Street No. 3945 FLORA AVENUE  
(If rural, give location)  
(e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 5 day 24  
year 44 hour 7:00 P.M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_;  
Ann

that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

Immediate cause of death: Cerebral edema  
Cerebral sclerosis

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

Due to Subarachnoid arteriosclerosis

Other conditions SCHOOL  
(Include pregnancy within 3 months of death) 872

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

Of autopsy See above

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) (e) Means of injury \_\_\_\_\_

23. Signature C. E. Brown Date signed 5/24/44

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

MOTHER FATHER

**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

*Emile M. Calhoun*

Licensed Embalmer No. 3506

P. O. Address K C Mo

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, above space should be left blank.**