

FILED SEP 7 1944

Primary Registration District No. 1002

Registrar's No.

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:
18th & Grand K.C. Star Building
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community 58 years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 48
(c) City or town Kansas City 3
(If outside city or town limits, write "RURAL") 8
(d) Street No. 4937 South Benton
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country no

3. (a) PRINT FULL NAME John G. Engberg

3. (b) If veteran, name war no 3. (c) Social Security No. 487 05 9414

4. Sex Male 5. Color or race Wh 6. (a) Single, widowed, married, divorced, Married
6. (b) Name of husband or wife Emma L. Engberg 6. (c) Age of husband or wife if alive 63 years
7. Birth date of deceased Sept. 10 1885
(Month) (Day) (Year)

8. AGE: Years 58 Months 11 Days 9 If less than one day hr. min.

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

10. Usual occupation Janitor Foreman K.C. Sta

11. Industry or business _____

MOTHER { 12. Name John A. Engberg
13. Birthplace Sweden 4
(City, town, or county) (State or foreign country)
14. Maiden name Unknown
15. Birthplace Unknown 7
(City, town, or county) (State or foreign country)

16. (a) Informant John W. Engberg
(b) Address 5018 Walrond
17. (a) Burial (b) Date thereof 8-23rd-1944
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Mt Washington Cem

18. (a) Signature of funeral director Clyar Funeral Home
(b) Address 1800 Linwood
19. (a) 8-23-44 (b) N. E. Brown
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 19th
year 1944 hour 12 minute 20 A. M.

21. I hereby certify that I attended the deceased from _____ 19____
that I last saw him/her alive on _____ 19____
and that death occurred on the date and hour stated above.

Immediate cause of death _____
Acute primary occlusion
Due to _____
Coronary artery disease
Due to _____

Other conditions (Include pregnancy within 3 months of death)

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) _____
Cause of injury _____
23. Signature A. E. Washer (M. D. or other) M.D.
Address 23rd & M. Ray Date signed 8/19/44

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

48
3
8

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.....

Charles Wilks

Licensed Embalmer No.....

2644

P. O. Address.....

1800 Linwood

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.