

FILED AUG 23 1944

Registration District No. _____

149

Primary Registration District No. _____

1002

Registrar's No. _____

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: Children's Mercy Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 11 weeks
(Specify whether years, months or days) 8-1-44 to 8-8-44

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri County J. Clay
(c) City or town Schell City Rural
(If outside city or town limits, write "RURAL")
(d) Street No. R.F.D. I 93
(If rural, give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Melvin Leroy Stroer

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

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

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

7. Birth date of deceased July 6 1942
(Month) (Day) (Year)

8. AGE: Years 2 Months 1 Days 2 If less than one day hr. _____ min. _____

9. Birthplace Eldorado Springs Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation Child

11. Industry or business _____

12. Name Clyde William Stroer

13. Birthplace Eldorado Springs, Mo.
(City, town, or county) (State or foreign country)

14. Maiden name Dorothy Elizabeth Corwith

15. Birthplace Eldorado Springs, Mo.
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Clyde Stroer (mother)
(b) Address Schell City, MO RR1

17. (a) Removal (b) Date thereof 8-9-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Clintonville Cemetery
18. (a) Signature of funeral director Gwinn Siderst
(b) Address Eldorado Springs, Mo.
19. (a) 8-9-44 (b) M. E. Brown
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 8
year 1944 hour 12 minute 55 AM

21. I hereby certify that I attended the deceased from 8-1-1944 to 8-8-1944;
that I last saw him alive on 8-8-1944;
and that death occurred on the date and hour stated above.

Immediate cause of death Shock
Due to Sarcoma, retro-peritoneal, type undetermined

Other conditions (Include pregnancy within 3 months of death) 46 hr.

Major findings: Of operations as above
Of autopsy _____

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 Alex Horvitz (M. D.)
Address Mercy Hospital Date signed 8/9/44

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

M. P. Linn

Licensed Embalmer No.

2084

P. O. Address

Edwards Ave. 7

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.