

FILED OCT 24 1944

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

33117
State File No.

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 4080

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 2 days
(Specify whether
In this community 10 Years
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")
(d) Street No. 1841 E. 7 St. 8
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country 0

3. (a) PRINT FULL NAME Frederick Enyart

3. (b) If veteran, name war. No. 3. (c) Social Security No. No.

4. Sex Male 0 5. Color or race White 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Nellie Enyart 6. (c) Age of husband or wife if alive 71 years
7. Birth date of deceased Sept 1 1870
(Month) (Day) (Year)

8. AGE: Years 74 Months 1 Days 8 If less than one day
hr. _____ min.

9. Birthplace Gardner Kansas. 1
(City, town, or county) (State or foreign country)

10. Usual occupation Morocco Missipnary. Retired.

11. Industry or business _____

12. Name Jerimiah Enyart

13. Birthplace Ohio 1
(City, town, or county) (State or foreign country)

14. Maiden name Eliza Ann Porter

15. Birthplace Pann 1
(City, town, or county) (State or foreign country)

16. (e) Informant Mrs Nellie Enyart

(b) Address 1841 E. 7th. St.

17. (a) Rural (b) Date thereof 10 12 1944
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Obitue James

18. (a) Signature of funeral director Mrs. L. J. Porter

(b) Address 912-920 Broadway

19. (a) 10-11-44 (b) P. E. Brown
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 9
year 1944 hour 2 minute P. M.

21. I hereby certify that I attended the deceased from Oct. 7, 1944 to Oct. 9, 1944
that I last saw him alive on Oct. 9, 1944
and that death occurred on the date and hour stated above.

Immediate cause of death Aspiration pneumonia *Duration*
and atelectasis

Due to _____

Due to _____

Other conditions 107
(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) (e) Means of injury 0

23. Signature A. E. Woster (M. D. or other) _____

Address Med. Dir. Gen'l Hosp. Date signed 10-10-44

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..... *C. N. Nie*

Licensed Embalmer No. *2570*

P. O. Address *K C 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.