

FILED NOV 13 1944

State File No. _____

Registration District No. 179

Primary Registration District No. 1002

Registrar's No. 4241

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: RESEARCH HOSPITAL
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 5 DAYS
(Specify whether _____)
In this community 24 YEARS
years, months or days

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. 501 WEST-11TH STREET
(If rural, give location)
(e) Citizen of foreign country? YES (Yes or No)
If yes, name country DENMARK

3. (a) PRINT FULL NAME MR. JAMES MARTIN JANSEN
3. (b) If veteran, name war NO
3. (c) Social Security No. 492-28-6364

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month OCTOBER day 21ST
year 1944 hour 11 minute 17 A. M.

4. Sex MALE 5. Color or race WHITE
6. (a) Single, widowed, married, divorced MARRIED
6. (b) Name of husband or wife MRS. GERTRUDE JANSEN
6. (c) Age of husband or wife if alive 65 years
7. Birth date of deceased DECEMBER 14 1882
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Oct 2, 1944 to Oct 21, 1944
that I last saw him alive on Oct 21, 1944
and that death occurred on the date and hour stated above.
Immediate cause of death Acute cardiac decompensation Duration _____

8. AGE: Years Months Days If less than one day
61 10 7 hr. _____ min.

Due to Coronary artery occlusion
Due to Generalized arteriosclerosis

9. Birthplace COPENHAGEN DENMARK
(City, town, or county) (State or foreign country)

10. Usual occupation SALESMAN

11. Industry or business DRUG SUPPLIES

MOTHER, FATHER { 12. Name MARCUS JANSEN
13. Birthplace COPENHAGEN DENMARK
(City, town, or county) (State or foreign country)
14. Maiden name UNKNOWN KNUDSEN
15. Birthplace COPENHAGEN DENMARK
(City, town, or county) (State or foreign country)

Other conditions (Include pregnancy within 3 months of death)
Major findings: Of operations none gsc Of autopsy none
PHYSICIAN _____ Underline the cause to which death should be charged statistically.

16. (a) Informant MRS. GERTRUDE JANSEN

(b) Address 501 WEST-11TH STREET

17. (a) BURIAL (b) Date thereof OCT-23-1944
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation GREEN LAWN CEMETERY

18. (a) Signature of funeral director D. H. Newcome, Sons

(b) Address 1401 BRUSH CREEK BLVD.

19. (a) OCT 23 1944 (b) J. Johnson
(Date received local registrar) (Registrar's signature)

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) _____ (c) Means of injury _____
Signature MO. J. Johnson (D. O. or other) _____
Address 2300 Holmes Date signed 21 Oct 44

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

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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 Elleear Hordley
Licensed Embalmer No. 1767
P. O. Address KE 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.