

FILED NOV 14 1944  
Registration District No. 194

Primary Registration District No. 1002

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

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:  
Missouri Kansas Elevator and Mo. P. Tr  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
In this community 50 years 3 (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County Jackson 42  
(c) City or town Kansas City 3  
(If outside city or town limits, write "RURAL")  
(d) Street No. 101 N. Indiana 5  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME WALTER MERRIFIELD  
3. (b) If veteran, name war World War I 3. (c) Social Security No. 702-18-0280

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month October day 29 year 1944 hour 5:30 minute 0 M.  
21. I hereby certify that I attended the deceased from Alpeyely Coomes 19\_\_\_\_; that I last saw h\_\_\_\_\_ alive on \_\_\_\_\_ 19\_\_\_\_; and that death occurred on the date and hour stated above.  
Immediate cause of death \_\_\_\_\_

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced, Married  
6. (b) Name of husband or wife Clara 6. (c) Age of husband or wife if alive 46 years  
7. Birth date of deceased Jan. 2, 1888  
(Month) (Day) (Year)

Coronary arterio occluded  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death) 94a

8. AGE: Years Months Days If less than one day  
56 9 27 hr. \_\_\_\_\_ min.

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

10. Usual occupation Switchman

11. Industry or business Missouri Pacific

MOTHER FATHER { 12. Name Unknown 9  
13. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)

14. Maiden name \_\_\_\_\_ 9  
15. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)

16. (a) Informant Clara Merrifield

(b) Address 101 N. Indiana

17. (a) Burial (b) Date thereof 11-1-44  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Paradise, Mo

18. (a) Signature of funeral director C. H. Cleckman & Son,

(b) Address Kansas City, Mo.

19. (a) 10-31-44 (b) N.E. Brown  
(Date received local registrar) (Registrar's signature)

PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.  
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? \_\_\_\_\_

(Specify type of place) (Specify means of injury)  
In (While at work) \_\_\_\_\_  
23. Signature A.E. Woster (M. D. or other) MD  
Address 23 rd & McCar Date signed 12/29/44

NOV 28 1954

**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 H. D. Bliskin  
Licensed Embalmer No. 5639  
P. O. Address R. C. M.

**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.**