V. S. No. 2
00M—5-43
Rev. 5-17-39
I X36671

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 36711

Registration District No. FILED DEC 4 1944

Primary Registration District No. 1002

Registrar's No. 4558

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~~ 33 DAYS (Specify whether
In this community 50 YEARS
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County JACKSON 49

(c) City or town KANSAS CITY
(If outside city or town limits, write "RURAL")

(d) Street No. 5723 OAK STREET
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME MRS CALLIE W. GARWOOD

3. (b) If veteran, name war No

3. (c) Social Security No. NONE

4. Sex FEMALE 1

5. Color or race WHITE

6. (a) Single, widowed, married, divorced WIDOWED 2

6. (b) Name of husband or ~~wife~~ MR. WILLIAM S. GARWOOD

6. (c) Age of husband or wife if alive ------ years

7. Birth date of deceased FEB (Month) 6 (Day) 1865 (Year)

8. AGE: Years 79 Months 9 Days 5 If less than one day ___ hr. ___ min.

9. Birthplace NEWBERG (City, town, or county) INDIANA (State or foreign country) 1

10. Usual occupation HOUSEWIFE

11. Industry or business —

FATHER
12. Name HENRY WEIKE 1
13. Birthplace UNKNOWN (City, town, or county) GERMANY (State or foreign country) 4

MOTHER
14. Maiden name CAROLINE SCHWARTZ
15. Birthplace UNKNOWN (City, town, or county) GERMANY (State or foreign country) 4

16. (a) Informant MRS. WALLACE SUTHERLAND 1

(b) Address 5723 OAK

17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof NOV. 13 1944 (Month) (Day) (Year)

(c) Place: burial or ~~cremation~~ MEMORIAL PARK

18. (a) Signature of funeral director D. W. Newcomers Sons

(b) Address 1401 Brush Creek Blvd. K.C. Mo

19. (a) 11-13-44 (Date received local registrar) (b) N. E. Brown (Registrar's signature)

MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month NOV. day 11th year 1944 hour 11 minute P. M.

21. I hereby certify that I attended the deceased from September 9, 1943 to November 11, 1944 that I last saw her alive on ~~Sept~~ Nov 11, 1944 and that death occurred on the date and hour stated above.

Immediate cause of death Bronchopneumonia

Due to

Due to

Other conditions Pneumonia of the Cervix
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy No

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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)

While at work? (e) Means of injury

23. Signature [signature] (M. D. or other) M.D.

Address 830 Argyle Bldg Date signed 11/12/44

(Licensed Embalmer's Statement on Reverse Side)

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. Oscar Worthey

Licensed Embalmer No. 1767

P. O. Address Kansas City

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.