

FILED DEC 9 1944
Registration District No. _____

Primary Registration District No. 1002

Registrar's No. _____

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:
4424 Norledge
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether)

In this community 4 Months
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Ohio (b) County Brown

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

(d) Street No. _____ (If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME John Fredrick List

3. (b) If veteran, name war No

3. (c) Social Security No. No

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November day 26th.
year 1944 hour 6 minute 15 A.M.

4. Sex Male 5. Color or race White

6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife unknown

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

7. Birth date of deceased 2 - 27 - 1864
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Nov 24, 1944, to Nov 26, 1944
that I last saw him alive on Nov 25, 1944
and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day

80 8 29 .hr. _____ min.

Immediate cause of death, _____
Permeious Peritonitis
Chronic Myocarditis

Duration 1 year 2 years

9. Birthplace Sardinia Ohio
(City, town, or county) (State or foreign country)

Due to _____

Due to _____

10. Usual occupation Farmer, Retired

Other conditions _____
(Include pregnancy within 3 months of death)

11. Industry or business _____

12. Name Unknown

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

14. Maiden name Unknown

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

Major findings:
Of operations None

Of autopsy None

PHYSICIAN _____
Underline the cause to which death should be charged statistically.

16. (a) Informant Mr. Merrill List

(b) Address 4424 Norledge

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? _____

17. (a) Removal (b) Date thereof 11-26-1944
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Sardinia, Ohio

While at work? _____ (Specify type of place)
(e) Means of injury _____

18. (a) Signature of funeral director Mrs. C.L. Forster

(b) Address Kansas City, Missouri

23. Signature W. E. Brown (M. D. broker)
Address 1039 N. Elmwood Date signed 11-26-44

19. (a) 11-26-44 (b) W. E. Brown
(Date received local registrar) (Registrar's signature)

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

2010

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

J. P. Herrick

Licensed Embalmer No. *5599*

P. O. Address *A. 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.