

FILED JAN 4 1945

Registration District No. **149**

Primary Registration District No. **1002**

Registrar's No. **5224**

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: St. Mary's Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 6 1/2 hours (Specify whether  
In this community 44 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. 2941 Forest (If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME MRS. ESTELL M. BISHOP

3. (b) If veteran, name war XX 3. (c) Social Security No. 495-05-4635

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month Dec. day 22d  
191944 year hour 6: minute 50 P.M.

4. Sex Fe 5. Color or race Wh 6. (a) Single, widowed, married, divorced Divorced  
6. (b) Name of husband or wife XX 6. (c) Age of husband or wife if alive XX years  
7. Birth date of deceased September 13 1899  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from 12/22/44, 191944 to 12/22/44, 191944  
that I last saw him alive on 12/22/44  
and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia hemorrhage Duration \_\_\_\_\_

8. AGE: Years 45 Months 3 Days 9 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

Due to \_\_\_\_\_  
Due to 83a  
Other conditions Department  
(Include pregnancy within 3 months of death)

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

10. Usual occupation Secretary Employers

11. Industry or business Reinsurance Corporation

12. Name Henry F. Hentzen

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

14. Maiden name Mary J. McBride Mo. Mo.

15. Birthplace Mrs. James A. Stanton Mo. Mo.  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. James A. Stanton

(b) Address R3 Kansas City, Mo.

17. (a) Burial (b) Date thereof 12-26-44  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Washington

18. (a) Signature of funeral director J. M. Wagner  
Kansas City, Mo.

(b) Address \_\_\_\_\_

19. (a) 12-23-44 (b) T. E. Brown  
(Date received local registrar) (Registrar's signature)

PHYSICIAN  
Major findings:  
Of operations \_\_\_\_\_  
Of autopsy See above  
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? \_\_\_\_\_

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

23. Signature [Signature] (M. D. or other) \_\_\_\_\_  
Address 1109 N. 1st St. Kansas City, Mo.

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

MOTHER FATHER

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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 Alvin R. Hainschell

Licensed Embalmer No. 4159

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.**