

FILED JAN 11 1945

Registration District No. **149**

Primary Registration District No. **1002**

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. Joseph Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **6 days** (Specify whether
In this community **50 years,** years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Kansas,** (b) County **Johnson,**
(c) City or town **Kansas City,**
(If outside city or town limits, write "RURAL")
(d) Street No. **5546 Crestwood Drive**
(If rural, give location)
(e) Citizen of foreign country? **NO.** (Yes or No)
If yes, name country **X**

3. (a) PRINT FULL NAME **Dr. John Martin Frankenburger**

3. (b) If veteran, name war **no.** 3. (c) Social Security No. **no.**

4. Sex **Male** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Married**

6. (b) Name of husband or wife **Ottella Frankenburger** 6. (c) Age of husband or wife if alive **unknown** years

7. Birth date of deceased **May 2 1869**
(Month) (Day) (Year)

8. AGE: Years **75** Months **7** Days **23** If less than one day hr. min.

9. Birthplace **Wisconsin** (City, town, or county) (State or foreign country)

10. Usual occupation **Physician**

11. Industry or business **X**

12. Name **Henry Frankenburger,**
13. Birthplace **unknown,** (City, town, or county) (State or foreign country)

14. Maiden name **Johns**
15. Birthplace **unknown** (City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. Ottella Frankenburger,**
(b) Address **5546 Crestwood Dr., K. C., Kansas**

17. (a) **Cremation** (b) Date thereof **12-27-44**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Elmwood Cemetery**

18. (a) Signature of funeral director **Stine & McClure,**
(b) Address **3235 Gillham Plaza, K. C., Mo.**

19. (a) **12-27-44** (b) **D. E. Brown**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **December** day **25th**
year **1944** hour **12:30** minute **P.** M.

21. I hereby certify that I attended the deceased from **12-19**, 19**44**, to **12-25**, 19**44**
that I last saw him alive on **12-25-44**, 19**44**
and that death occurred on the date and hour stated above.

Immediate cause of death

Peritonitis following resection of colon for carcinoma

Due to **Uremia from nephrosclerosis**

Other conditions (Include pregnancy within 3 months of death) **462**

Major findings: Of operations **as above**

Of autopsy

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 **Vincent Williams** (M. D. or other)
Address **836 Maple Blvd** Date signed **Per 27**

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

8
3
8

999
14
0
7

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

D. V. T. Williams

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

S. J. Allen

Licensed Embalmer No. *1415*

P. O. Address *H. C. [unclear]*

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.