

FILED DEC 22 1944

Registrar's No. **5030**

Registration District No. **199**

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: **Mercy Hospital**
(If not in hospital or institution, write street number or location) **0**
(d) Length of stay: In hospital or institution **7 days**
(Specify whether years, months or days) **7 days**

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Jackson**
(c) City or town **Chillicothe**
(If outside city or town limits, write "RURAL") **2**
(d) Street No. _____
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country **1**

3. (a) PRINT FULL NAME **Donald Henry Karst**

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

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

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

7. Birth date of deceased **Feb. 25 1930**
(Month) (Day) (Year)

8. AGE: Years **14** Months **9** Days **17** If less than one day hr. _____ min. _____

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

10. Usual occupation **Child**

11. Industry or business _____

MOTHER FATHER

12. Name **Christian Leo Karst**

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

14. Maiden name **Lillian F. Baxter**

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

16. (a) Informant **Lillian F. Karst**

(b) Address **Chillicothe Mo.**

17. (a) **Removal** (b) Date thereof **Dec. 12 1944**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Chillicothe Mo.**

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

(b) Address **918 Brooklyn**

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **12** day **12**
year **1944** hour **6-** minutes **30** A.M.

21. I hereby certify that I attended the deceased from _____ 19____ to _____ 19____
that I last saw h_____ alive on _____ 19____
and that death occurred on the date and hour stated above.

Immediate cause of death _____

Pneumonia - Left Lung -

Due to **Following Factors of 4th Lobar Ventral -**

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

Major findings: Of operations **as above 18 to 15 - 8**

Of autopsy **yes 40**

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) **Following accident**

(b) Date of occurrence **12-5-44 4PM**

(c) Where did injury occur? **Chillicothe Mo**
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
Public Place

While at work? **NO** (Specify type of place)

(e) Means of Injury **Playing Badminton**

23. Signature **Jimmie Miller** (M. D. or other)

Address **1424 N. 1st St. Chillicothe Mo** Date signed **12-12-44**

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 Wm H. Jackson
Licensed Embalmer No. 3954
P. O. Address K 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.