

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 General Hospital
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 2 days
(Specify whether)
 In this community 30 years
years, months or days

2. USUAL RESIDENCE OF DECEASED:
 (a) State Mo. (b) County Jackson 48
 (c) City or town Kansas City 2
(If outside city or town limits, write "RURAL")
 (d) Street No. 807 East 14th St. 8
(If rural, give location)
 (e) Citizen of foreign country? 0 (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME Miss Barbara Mohner

3. (b) If veteran, name war no 3. (c) Social Security No. none

4. Sex Female 5. Color or race white 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 No record
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>58</u>			hr. _____ min.

9. Birthplace Germany 4
(City, town, or county) (State or foreign country)

10. Usual occupation H.D. Lee Co. 12 yrs. ago

11. Industry or business _____

12. Name No record

13. Birthplace Germany 4
(City, town, or county) (State or foreign country)

14. Maiden name No record

15. Birthplace Germany 4
(City, town, or county) (State or foreign country)

16. (a) Informant Joseph H. Fehn

(b) Address 281 South Mill St. K.C.A.

17. (a) Burial (b) Date thereof Jan. 15, 1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary

18. (a) Signature of funeral director Thos. E. Quirk Funeral
4316 Troost Ave.

(b) Address _____
 19. (a) 1-13-45 (b) T. E. Brown (Registrar's signature)

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month 1 day 11
 year 1945 hour 9:45 minute A M.

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

Immediate cause of death	Duration
<u>Coronary sclerosis</u>	
Due to <u>arterio sclerosis</u>	
Due to _____	

Other conditions 942
(Include pregnancy within 3 months of death)

Major findings: History & Inspection
 Of operations _____
 Of autopsy not

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? Home
(Specify type of place)

23. Signature James Walker (M. D. or other) Coroner

Address 1424 Poplar Blvd Date signed 1-15-45

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

MOTHER FATHER

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.....

Thomas E. L...

Licensed Embalmer No. 3775

P. O. Address. R.C. Me

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.