

FILED JAN 26 1945

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:  
K. C. General Hospital No. 1  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 1 day 8 hrs  
(Specify whether  
In this community same  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Ferry 5  
(c) City or town Monett Missouri 7  
(If outside city or town limits, write "RURAL") 1  
(d) Street No. \_\_\_\_\_  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country 1

3. (a) PRINT FULL NAME Chas. E. Mansfield

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

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married  
6. (b) Name of husband or wife Maud Mansfield 6. (c) Age of husband or wife if alive 55 years  
7. Birth date of deceased April 18 1885  
(Month) (Day) (Year)

8. AGE: Years 59 Months 8 Days 22 If less than one day 21 hr. \_\_\_\_\_ min.

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

10. Usual occupation Mens Clothing Store

11. Industry or business Owner

MOTHER FATHER { 12. Name James Mansfield  
13. Birthplace Unknown Indiana  
(City, town, or county) (State or foreign country)  
14. Maiden name Anna Higgens  
15. Birthplace Unknown Missouri  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs Maud Mansfield  
(b) Address Monett, Missouri

17. (a) Removal (b) Date thereof 1-9-45  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Monett, Missouri

18. (a) Signature of funeral director Melody-McGilley

(b) Address Kansas City, Missouri

19. (a) 1-9-45 (b) J. E. Brown  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 9  
year 1945 hour 6 minute 20 AM.

21. I hereby certify that I attended the deceased from Jan. 7 1945 to Jan. 9 1945

that I last saw him alive on Jan. 9 1945

and that death occurred on the date and hour stated above.

Immediate cause of death Coronary occlusion Duration \_\_\_\_\_

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions 94a  
(Include pregnancy within 3 months of death)

Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_

Of autopsy None

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) \_\_\_\_\_  
Means of injury \_\_\_\_\_

23. Signature A. E. Upsher (M. D. or \_\_\_\_\_) MS  
Address Med. Dir. Cent'l Hosp. Date signed 1-9-45

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

MAY 31 1945

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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.....

Licensed Embalmer No.....

P. O. Address.....

**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.**