

Registration District No. **149** 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:  
45 Minuets Gen. Hosp. C  
(If not in hospital or institution, write street number, or location)  
(d) Length of stay: In hospital or institution 45 min  
(Specify whether  
In this community 1 day  
years, months or days)

**3. (a) PRINT FULL NAME** Christ H. Meinsen  
**3. (b) If veteran,** name war No  
**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** Sallie Meinsen  
**6. (c) Age of husband or wife if alive** unk years  
**7. Birth date of deceased** August 6 1869  
(Month) (Day) (Year)

**8. AGE:**

Years	Months	Days	If less than one day
75	6	5	hr. min.

**9. Birthplace** Germany  
(City, town, or county) (State or foreign country)  
**10. Usual occupation** Retired

**11. Industry or business** Meat Cutter

**MOTHER FATHER**

**12. Name** Wm. Meinsen  
**13. Birthplace** Germany  
(City, town, or county) (State or foreign country)  
**14. Maiden name** Christina  
**15. Birthplace** Germany  
(City, town, or county) (State or foreign country)

**16. (a) Informant** Sallie Meinsen  
**(b) Address** Agency Missouri

**17. (a) Removal** (Burial, cremation, or removal) Agency Missouri  
**(b) Date thereof** Feb. 13 1945  
(Month) (Day) (Year)  
**(c) Place: burial or cremation** Agency Missouri

**18. (a) Signature of funeral director** Mrs. C. L. Forster  
**(b) Address** 918 Brooklyn

**19. (a)** 2-13-45 **(b)** N. E. Brown  
(Date received local registrar) (Registrar's signature)

**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. Agency Missouri  
(If rural, give location)  
(e) Citizen of foreign country? 1 (Yes or No)  
If yes, name country \_\_\_\_\_

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH:** Month 2 day 11  
year 1945 hour 9:02 minute 0 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**  
Skull fracture (Base)

**Due to** \_\_\_\_\_  
**Due to** \_\_\_\_\_  
**Other conditions** 1862-5  
(Include pregnancy within 3 months of death) 18

**Major findings:**  
**Of operations** History + Inspection  
**Of autopsy** no

**Duration** \_\_\_\_\_  
**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) accident  
(b) Date of occurrence 2-11-45 7:30 pm  
(c) Where did injury occur? 446 Indiana K.E. Jackson - Mo  
(City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place?  
In Home

**While at work?** no **(c) Means of injury** Fall

**23. Signature** James C. Walker **(M.D. or other)** 2 Brown  
**Address** 1424 Princeton Bldg **Date signed** 2-12-45

**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.....

*Theron A. Redman*

Licensed Embalmer No.....

*2737*

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.**