

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED MAR 7 1945

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 860

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 14 days
(Specify whether years, months or days)
 In this community 60 yrs

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. 5012 Scarritt
(If rural, give location)
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME Jake S. Sphar

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

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

6. (b) Name of husband or wife Caroline Sphar
 6. (c) Age of husband or wife if alive unk years

7. Birth date of deceased Sept. 30, 1870
(Month) (Day) (Year)

8. AGE: Years 74 Months 4 Days 20
 If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business Retired

12. Name Unknown

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

14. Maiden name Unknown

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

16. (a) Informant Caroline Sphar

(b) Address 5012 Scarritt

17. (a) Buried (b) Date thereof 2-22-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Mary's Mt. Washington St. Marys.

18. (a) Signature of funeral director Quirk & Blin

(b) Address 20 West Linwood

19. (a) 2-21-45 (b) D. E. Brown
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month February day 20
 year 1945 hour 2 minute 35 P.M.

21. I hereby certify that I attended the deceased from February 6, 1945 to February 20, 1945
 that I last saw him alive on February 20, 1945
 and that death occurred on the date and hour stated above.

Immediate cause of death Acute pulmonary infarction due to cardiac decompensation

Due to _____

Due to _____

Other conditions 956
(Include pregnancy within 3 months of death)

Major findings: _____
 Of operations _____

Of autopsy See above

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 Clark W. Seelye
 Address Med. Dir. Gen'l Hosp. Date signed 2-21-45

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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..... *Charles M. Quirk*

Licensed Embalmer No. *3774*

P. O. Address *Jamieson City, 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.