

U.S. No. 2
FORM-5-43
Rev. 5-17-39
I X36871

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **8545**

FILED APR 5 1945
Registration District No. **799**

Primary Registration District No. **1002**

Registrar's No. **1258**

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** **D**
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution **9 days**
(Specify whether years, months or days)
 In this community **30 years**

2. USUAL RESIDENCE OF DECEASED:
 (a) State **Missouri** (b) County **Jackson** **49**
 (c) City or town **Kansas City** **3**
(If outside city or town limits, write "RURAL")
 (d) Street No. **7429 Prospect** **8**
(If rural, give location)
 (e) Citizen of foreign country? **no** **0** (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME **Pearle W. Deem**
 (b) If veteran, name war **no**
 (c) Social Security No. **491-20-6501**

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **March** day **17**
 year **1945** hour **1** minute **15 A.M.**

4. Sex **male** **D** **5. Color of race** **White** **6. (a) Single, widowed, married, divorced** **married**
6. (b) Name of husband or wife **Gladyz Deem** **6. (c) Age of husband or wife if alive** **63** years
7. Birth date of deceased **Nov. 5 1882**
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **March 8 1945** to **March 17 1945**
 that I last saw him alive on **March 17 1945**
 and that death occurred on the date and hour stated above.

8. AGE: Years **62** Months **4** Days **12** If less than one day _____ hr. _____ min.

Immediate cause of death **Encephalomalacia** **Duration** _____

9. Birthplace **Parkersburg West Va.**
(City, town, or county) (State or foreign country)

Due to **Arteriosclerosis**

10. Usual occupation **Sheet Metal Worker**

Due to _____

11. Industry or business **W. C. Weidemann**

Other conditions. **83C**
(Include pregnancy within 3 months of death)

12. Name **Dont know**

Major findings:
 Of operations _____

13. Birthplace " " **9**

Of autopsy **None**

14. Maiden name **Dont know** **9**

15. Birthplace " " **9**

16. (a) Informant **Gail R. Stevenson**

(b) Address **De Soto Kans RR #1**

17. (a) Burial **(b) Date thereof** **3-20-45**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Memorial Park**

22. If death was due to external causes, fill in the following:

18. (a) Signature of funeral director **Freeman Mortuary**
(b) Address **Kansas City, Mo**

(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? _____

19. (a) 3-19-45 **(b) D. E. Brown**
(Date received local registrar) (Registrar's signature)

23. Signature **Clark W. Seely MD**
(M.D. or other)

Address **Med. Dir. Gen'l Hosp.** Date signed **3-17-45**

(Licensed Embalmer's Statement on Reverse Side)

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.....

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.