. S. No. 2
0M—2-43
v. 5-17-39
1 X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAR 24 1945

Registration District No. 149

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 1002

State File No. 8717

Registrar's No. 1133

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 17 days (Specify whether years, months or days)

In this community 12 years

2. USUAL RESIDENCE OF DECEASED:

(a) State: Missouri (b) County: Jackson 48

(c) City or town: Kansas City 3
(If outside city or town limits, write "RURAL")

(d) Street No.: 920 Locust 8
(If rural, give location)

(e) Citizen of foreign country? 0 (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME: Fred A. Mott

3. (b) If veteran, name war: NO

3. (c) Social Security No.: NO

4. Sex: M 0

5. Color or race: W

6. (a) Single, widowed, married, divorced: widowed

6. (b) Name of husband or wife: Mrs Alice E Mott

6. (c) Age of husband or wife if alive — years

7. Birth date of deceased: June (Month) 28 (Day) 1862 (Year)

8. AGE: Years 83 Months 8 Days 18 If less than one day ___ hr. ___ min.

9. Birthplace: New York (City, town, or county) (State or foreign country)

10. Usual occupation: Retired 3 years

11. Industry or business:

MOTHER FATHER

12. Name: John Mott

13. Birthplace: New York State (City, town, or county) (State or foreign country)

14. Maiden name: Maria Sackenberg

15. Birthplace: New York State (City, town, or county) (State or foreign country)

16. (a) Informant: James G Shahoen

(b) Address: 8 Quincy Manor

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: March 10 (Month) (Day) (Year)

(c) Place: burial or cremation: Mt Moriah

18. (a) Signature of funeral director: J W Spencer

(b) Address: 1401 Brush Creek

19. (a) 3-10-45 (Date received local registrar) (b) D. E. Brown (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 8 year 1945 hour 1 minute 15 P.M.

21. I hereby certify that I attended the deceased from February 19 1945 to March 8 1945 that I last saw him alive on March 8 1945 and that death occurred on the date and hour stated above.

Immediate cause of death: Bronchopneumonia — Duration

Due to:

Due to:

Other conditions (Includes pregnancy within 3 months of death): 107

Major findings: Of operations:

Of autopsy: None

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? (Specify type of place)

While at work? (e) Means of injury: 0

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

Address: Med. Dir. Gen'l Hosp. Date signed: 3-8-45

(Licensed Embalmer's Statement on Reverse Side)

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 B. C. Newcomer Jr

Licensed Embalmer No. 40 #3

P. O. Address R.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.