

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED MAR 29 1945

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 1191

1. PLACE OF DEATH: Jackson
 (a) County Kansas City
 (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 4 days
 (Specify whether
 In this community unknown
 years, months or days)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Kansas (b) County 977
 (c) City or town Wichita 14
 (If outside city or town limits, write "RURAL")
 (d) Street No. Not known 9
 (If rural, give location)
 (e) Citizen of foreign country? 2 (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME William Zander
 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 unknown
 6. (b) Name of husband or wife unknown 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased Not known
 (Month) (Day) (Year)

8. AGE: Years 68 Months _____ Days _____ If less than one day
 hr. _____ min. _____

9. Birthplace Not known 4
 (City, town, or county) (State or foreign country)

10. Usual occupation Not known

11. Industry or business Not known

MOTHER FATHER { 12. Name Not known
 13. Birthplace Not known 9
 (City, town, or county) (State or foreign country)
 14. Maiden name Not known
 15. Birthplace Not known 9
 (City, town, or county) (State or foreign country)

16. (a) Informant Record Clerk
 (b) Address K. C. General Hospital No. 1

17. (a) Burial (b) Date thereof 3-14-45
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Redeemer

18. (a) Signature of funeral director Wm. A. Thompson
 (b) Address City, Missouri
 19. (a) 3-13-45 (b) T. S. Brown (103)
 (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 2
 year 1945 hour 7 minute 15 P.M.

21. I hereby certify that I attended the deceased from February 26 1945 to March 2 1945
 that I last saw him alive on March 2 1945
 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral vascular accident Duration _____

Due to _____

Due to _____

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

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? _____

While at work? _____ (Specify type of place)
 (a) Means of injury _____

23. Signature Clark W. Seely (M.D. or other) _____
 Address Med. Dir. Gen'l Hosp. Date signed 3-3-45

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

48
3
8

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.....

not embalmed

....., Registered Apprentice No.....

working under my personal supervision.

Signed.....

Wm. A. Schuyler

Licensed Embalmer No.....

3089

P. O. Address.....

150 9th

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.