

FILED MAY 15 1945
Registration District No. 177

Primary Registration District No. 1002

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: General Hospital #1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 23-DAYS
(Specify whether years, months or days)
In this community 58 YEARS

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. 4007 McGee
(e) If foreign born, how long in U. S. A. 58 YRS. years.

3. (a) PRINT FULL NAME Hellberg, William

3. (b) If veteran, name war NONE 3. (c) Social Security No. NONE

4. Sex MALE 5. Color or race WHITE 6. (a) Single, widowed, married, divorced WIDOWED
6. (b) Name of husband or wife MRS. ANNA M. HELLBERG 6. (c) Age of husband or wife if alive ----- years
7. Birth date of deceased FEBRUARY-24-1863
(Month) (Day) (Year)

8. AGE: Years 82 Months 2 Days 2 If less than one day hr. min.

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

10. Usual occupation SHOEMAKER

11. Industry or business RETIRED 8 YEARS.

12. Name FRITZ HELLBERG

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

14. Maiden name UNKNOWN

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

16. (a) Informant F. H. Hellberg

(b) Address 918 Tyler St. Cassoka Mo.

17. (a) BURIAL (b) Date thereof APR-30-1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation MT. WASHINGTON CEM.

18. (a) Signature of funeral director W. H. Newcomer Sons

(b) Address 1401 BRUSH CREEK BLVD

19. (a) 4-30-95 (b) Staldine Holmes
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 26
year 1945 hour 10 minute 00 P. M.

21. I hereby certify that I attended the deceased from April 3 45 to April 26 45;
that I last saw h. im alive on April 26 45;
and that death occurred on the date and hour stated above.

Immediate cause of death Hypostatic pneumonia, Bronchial
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) (e) Means of injury

23. Signature Clark W. Seely (M.D. or other) MD
Address Med. Dir Gen'l Hosp. Date signed 4-28-45

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 *Emile M. Calloway*

Licensed Embalmer No. *3506*

P. O. Address *Te 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.