

FILED APR 23 1945

Registration District No. 149

Primary Registration District No. 1002

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

1. PLACE OF DEATH: Jackson

(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: Trinity Lutheran  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 9 days  
In this community 7 years  
(Specify whether years, months or days)

3. (a) PRINT FULL NAME JOHN N NACHBAR

3. (b) If veteran, name war No 3. (c) Social Security No. 486-03-5871

4. Sex Ma 5. Color or race Wh 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Louise M. Nachbar 6. (c) Age of husband or wife if alive 49 years

7. Birth date of deceased October 11 1895  
(Month) (Day) (Year)

| 8. AGE: | Years     | Months   | Days      | If less than one day |
|---------|-----------|----------|-----------|----------------------|
|         | <u>51</u> | <u>5</u> | <u>21</u> | hr. min.             |

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

10. Usual occupation Machinist

11. Industry or business Lake City Ordnance Plant

12. Name Joseph Nachbar

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

14. Maiden name Mary Schwabengruber

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

16. (a) Informant Mrs. Louise M. Nachbar

(b) Address Rt. 1 Shawnee, Kansas

17. (a) Burial (b) Date thereof 4-5-45  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary

18. (a) Signature of funeral director J. M. Wagner  
(b) Address Kansas City, Mo.

19. (a) 4-3-45 (b) G. Holmes  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Kansas (b) County Johnson

(c) City or town Shawnee City  
(If outside city or town limits, write "RURAL")

(d) Street No. R#1 (Elm Street)  
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 4 / 9 / 45  
year hour minute M.

21. I hereby certify that I attended the deceased from 10/30/44 to 4/2/45, 19\_\_\_\_, to 19\_\_\_\_, and that death occurred on the date and hour stated above.

Immediate cause of death Myelogenous Leukemia (Acute)

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions 740  
(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 J. M. Wagner (M. D. or other) \_\_\_\_\_  
Address 1901 S. Wood Date signed 4/2/45

Duration 3 1/2 mo  
PHYSICIAN  
Underline the cause to which death should be charged statistically.

**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 Alvin R. Hunschild

Licensed Embalmer No. 4159

P. O. Address Kansas 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.**