

FILED APR 23 1945

Registration District No. 149

Primary Registration District No. 1002

Registrar's No.

1. PLACE OF DEATH:

(a) County Jackson City
 (b) City or town Jackson City
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
572 Woodland
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
(Specify whether)
 In this community 50 years
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson
 (c) City or town Jackson City
(If outside city or town limits, write "RURAL")
 (d) Street No. 3415 E 3rd
(If rural, give location)
 (e) Citizen of foreign country? _____
(Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME

Olga Von Trost
 (b) If veteran, name war _____
 (c) Social Security No. none

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 4 day 4
 year 45 hour 2 minute 17 M.
 21. I hereby certify that I attended the deceased from 3/2/45, 19____, to 4/4/45, 19____;
 that I last saw him alive on 4/4/45, 19____;
 and that death occurred on the date and hour stated above.

4. Sex Female 5. Color of hair White 6. (a) Single, widowed, married, divorced Married
 6. (b) Name of husband or wife Herman Von Trost 6. (c) Age of husband or wife if alive 62 years
 7. Birth date of deceased _____
(Month) (Day) (Year)

Immediate cause of death
Arteriosclerotic heart disease

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

9. Birthplace St. Louis, Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation None

11. Industry or business _____

12. Name Joseph Dietrich
 13. Birthplace Germany
(City, town, or county) (State or foreign country)

14. Maiden name Not known
 15. Birthplace Not known
(City, town, or county) (State or foreign country)

16. (a) Informant Emil Dietrich
 (b) Address 857 Minnesota Ave.

17. (a) Burial (b) Date thereof 4-7-45
(Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Higland Park

18. (a) Signature of funeral director H. H. Hanson
 (b) Address 1001 E. 12th

19. (a) 4-5-45 (b) J. Holmes
(Date received local registrar) (Registrar's signature)

Due to _____
 Due to _____
 Other conditions nutritional deficiency
(Include pregnancy within 3 months of death)

Major findings: _____
 Of operations _____
 Of autopsy Chemical findings

Duration _____
 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) (c) Means of injury
 23. Signature [Signature] Date signed 4/5/45
 Address 1109 Park Ridge

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.

Signature

George M. Halley

Licensed Embalmer No. *27,98*

P. O. Address *W. C. Kansas*

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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 12 558
Registrar's No. 1541

Registration District No. 149 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:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether _____)
In this community _____ (Specify whether _____)
years, months or days

3. (a) PRINT FULL NAME Olga Von Quast

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced m

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased unk (Month) _____ (Day) _____ (Year) _____

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

9. Birthplace app 68 (City, town, or county) _____ (State or foreign country) MO

10. Usual occupation _____

11. Industry or business _____

12. Name _____

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

14. Maiden name _____

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

16. (a) Informant _____

(b) Address _____

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

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 4-5-45 (Date received local registrar) (b) Heraldine Holmes (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____ (If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ day _____ year 1945 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19____ to _____ 19____; that I last saw him/her alive on _____ 19____; and that death occurred on the date and hour stated above.
Immediate cause of death _____

Due to _____

Due to _____

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

Major findings: Of operations _____

Of autopsy _____

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 _____ (M. D. or other)

Address _____ Date signed _____

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

SUPPLEMENTARY

