

S. No. 2
DM-5-43
v. 5-17-39
I X36671

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **12578**
Registrar's No. **1583**

FILED APR 23 1945
Registration District No. **749**

Primary Registration District No. **1002**

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

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 4 days
(Specify whether years, months or days) 14 year

3. (a) PRINT FULL NAME Arthur M. White

3. (b) If veteran, name war Do not know

3. (c) Social Security No. Do not know

4. Sex male

5. Color or race white

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

6. (b) Name of husband or wife

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

7. Birth date of deceased Jan 29 1862
(Month) (Day) (Year)

8. AGE: Years 83 Months 2 Days 6 If less than one day
.....hr.min.

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

10. Usual occupation Retire

MOTHER FATHER

11. Industry or business

12. Name Do not know

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

14. Maiden name Do not know

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

16. (a) Informant General Hospital

(b) Address K C Mo

17. (a) Buried (Burial, cremation, or removal)

(b) Date thereof April 9-45
(Month) (Day) (Year)

(c) Place: burial or cremation mt Calvary Mch.

18. (a) Signature of funeral director Parrantino Bros

(b) Address K C Mo

19. (a) 4-7-45 (Date received local registrar)

(b) Richard H. Apples (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson **49**

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

(d) Street No. St. Christopher's Inn
(If rural, give location)

(e) Citizen of foreign country? 0 (Yes or No)
If yes, name country.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 5
year 1945 hour 9 minute 45 P.M.

21. I hereby certify that I attended the deceased from April 1, 1945, to April 5, 1945
that I last saw him alive on April 5, 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Congestive heart failure

Due to

Due to

Other conditions (Include pregnancy within 3 months of death) 93 2

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)

(2) Means of injury

23. Signature Clark W Sealy MD (M. D. or other) **4-6-45**
Address Med. Dir. Gen'l Hosp. Date signed

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 Francis Walter

Licensed Embalmer No. 2744

P. O. Address H. C. Md

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.