

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED MAY 3 1945
Registration District No. 149

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 12582
Registrar's No. 1764

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 25 days
(Specify whether
In this community 30 yrs
years, months or days)

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. 15 E. 6 St.
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country.

3. (a) PRINT FULL NAME Harry Whisman
3. (b) If veteran, name war no 3. (c) Social Security 4-86-16-3879

4. Sex M 5. Color or race W 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 Oct. 23 - 1888
(Month) (Day) (Year)

8. AGE: Years 56 Months 5 Days 24 If less than one day _____ hr. _____ min.

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

10. Usual occupation News agent - Cash

11. Industry or business _____

12. Name Chas J. Whisman

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

14. Maiden name Matie Neighbors

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

16. (a) Informant Chas Whisman

(b) Address 225 Benton

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/19/45 (Month) (Day) (Year)

(c) Place: burial or cremation Sedalia mo.

18. (a) Signature of funeral director Helen Kay

(b) Address 1161 2nd

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 17 year 1945 hour 5 minute A. M.

21. I hereby certify that I attended the deceased from March 23, 1945, to April 17, 1945 that I last saw him alive on April 17, 1945 and that death occurred on the date and hour stated above.

Immediate cause of death Congestive heart failure 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 _____

21. Signature Clark W. Seely or other _____

Address Med. Dir. Gen'l Hosp. Date signed 4-17-45

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.....

William Rose

Licensed Embalmer No..... *2810*

P. O. Address..... *11 E. 4th*

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.