

TKED JUL 3 1945

Registration District No. 149

Primary Registration District No. 1002

Registrar's No.

2600

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:  
3221 Chestnut  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 67 Years  
(Specify whether  
In this community 67 Years  
years, months or days)

3. (a) PRINT FULL NAME CHARLES A. WASSON

3. (b) If veteran, name war No 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 Elizabeth Wasson 6. (c) Age of husband or wife if alive 5th. years  
7. Birth date of deceased July 5th. 1858  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
86 11 12 hr. min.

9. Birthplace St. Johns New Brunswick, Canada  
(City, town, or county) (State or foreign country)

10. Usual occupation Retired

11. Industry or business Clerk

12. Name Archibald Wasson

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

14. Maiden name Mary Jane Ramsey

15. Birthplace St. Johns, New Brunswick, Canada  
(City, town, or county) (State or foreign country)

16. (a) Informant Charles D. Wasson

(b) Address 627 West 62nd.

17. (a) Burial (b) Date thereof 6 / 19 / 1945  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Forest Hill Cemetery

18. (a) Signature of funeral director Freeman Mortuary & Chapel

(b) Address 104 West 42nd. Street

19. (a) 6-18-45 (b) Geraldine Halmer  
(Date received local registrar) (Registrar's signature)

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. 3221 Chestnut St.  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 17  
year 1945 hour pm minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from 1944  
19\_\_\_\_, to June 17, 1945  
that I last saw him alive on June 17, 1945  
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral hemorrhage Duration 24h.

Due to arterio-sclerosis ?  
myocardial Chronic

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

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings: 93d

Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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?

(Specify type of place)  
While at work? \_\_\_\_\_

(e) Means of injury 0

23. Signature Wm. Jackson (M. D. or other) MD  
Address 1107 Broadway Date signed 6/18/45

PHYSICIAN  
Underline the cause to which death should be charged statistically.

145

*Dr Wm Jackson  
1-0-06 Bryant Bldg.*

**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..... *Elmer C. Wedel*.....

Licensed Embalmer No. *3495-*.....

P. O. Address *H. C. 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.**