

FILED JUN 10 1945
Registration District No. 948

Primary Registration District No. 5568

Registrar's No. 126

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Kansas City Mo.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
215 Ash Ave Blue Turp.!
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether _____)

In this community 78 years.
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Jackson ⁴⁸

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

(d) Street No. 2614 Holme, K.C.
(If rural, give location)

(e) Citizen of foreign country? no ⁰ (Yes or No)

If yes, name country _____

3. (a) PRINT FULL NAME MISS ELIZABETH BECKER

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 3
year 1945 hour _____ minute 1st A.M.

21. I hereby certify that I attended the deceased from June 3
1943 to May 3 1945

that I last saw her alive on May 1 1945
and that death occurred on the date and hour stated above.

4. Sex Female 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 _____

7. Birth date of deceased Oct 28 1852
(Month) (Day) (Year)

Immediate cause of death _____
Valvular Heart Disease
to become paralytic

Due to _____

Due to _____

Duration

6 mo

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

92 6 6 _____ hr. _____ min.

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

10. Usual occupation Retired

11. Industry or business _____

MOTHER FATHER { 12. Name Adam Becker

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

14. Maiden name Katherine Feig

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

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

Major findings: _____

Of operations no operation

Of autopsy no autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

16. (a) Informant Geo. W. Frick

(b) Address 215 Ash Ave Fairmount Mo.

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

(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Ch. Threigen

(b) Address 2512 Holme St

19. (a) 5-3-1945 (b) James W. Ross
(Date received local registrar) (Registrar's signature)

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 C. H. Allen (M. D. or other) MD

Address Inde Pendereel Date signed May 3 45

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

1163

FORM 36A OHL

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 PA Shuman.....

Licensed Embalmer No. 2381.....

P. O. Address: 2512 Halme St......

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. July
Registrar's No. 126

Registration District No. 146 Primary Registration District No. 5568

1. PLACE OF DEATH:
(a) County Jackson
(b) City or town Inter City Dist. Blue Twp.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
215 Ash Ave. F.M.T. STATION
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether _____)
In this community _____
years, months or days

3. (a) PRINT FULL NAME Elizabeth Becker
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 _____
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Oct 28 (Month) (Day) (Year)

8. AGE: Years 92 Months _____ Days _____ If less than one day _____ hr. _____ min.
9. Birthplace _____ (City, town, or county) (State or foreign country) Ohio

10. Usual occupation _____
11. Industry or business _____
MOTHER, FATHER { 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) _____ (b) Date thereof _____ (Month) (Day) (Year)
(Burial, cremation, or removal) (Specify type of place)
(c) Place: burial or cremation _____
18. (a) Signature of funeral director _____ (b) Address _____
19. (a) _____ (b) _____ (Date received local registrar) (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 _____ 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 _____

SUPPLEMENTARY

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

5-20491