

FILED JUN 19 1945

Registration District No. \_\_\_\_\_

Primary Registration District No. 3069

Registrar's No. 1525

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

1. PLACE OF DEATH:

(a) County St. Louis

(b) City or town Richmond Heights  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: St. Mary's Hospital  
(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

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. 5324 Virginia  
(If rural, give location)

(e) Citizen of foreign country? 1 (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Julia Helms

3. (b) If veteran, name war Nil

3. (c) Social Security No. Unknown

4. Sex Female 5. Color or race White

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

6. (b) Name of husband or wife Joseph D. Helms

6. (c) Age of husband or wife if alive 26 years

7. Birth date of deceased January 28 1920  
(Month) (Day) (Year)

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

25 4 10 hr. min.

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

10. Usual occupation Housewife

11. Industry or business \_\_\_\_\_

12. Name Charles LeCluyse

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

14. Maiden name Cora Schleicher

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

16. (a) Informant Charles LeCluyse

(b) Address Kansas City, Mo.

17. (a) Burial (b) Date thereof 6-11-45  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Kansas City, Mo.

18. (a) Signature of funeral director Albert H. Hoppe

(b) Address 4700 Washington Blvd.

19. (a) JUN 11 1945 (b) E. G. McCarson  
(Date received local Registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 8<sup>th</sup>  
year 1945 hour 6:10 minute A. M.

21. I hereby certify that I attended the deceased from May 25, 1945, to June 8, 1945,  
that I last saw her alive on June 7, 1945,  
and that death occurred on the date and hour stated above.

Immediate cause of death Acute Myocardial Failure Duration 6/8/45

Due to Myocardial Failure - Depressive Psychosis 5/25/45

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

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

PHYSICIAN

Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

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 Walter Moore (M. D. or other) M.D.  
Address 5400 Arsenal St Date signed 6/8/45

AMG 231961345

OCT 6 - 1948

**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 Albert G. Koppe  
Licensed Embalmer No. 2971

P. O. Address.....

**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.