

FILED AUG 4 1945 STANDARD CERTIFICATE OF DEATH

State File No. 22936

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 3138

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: General Hospital
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 23 days
(Specify other)
 In this community unham
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. 1219 Holmes
(If rural, give location)
 (e) Citizen of foreign country? 0
(Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME Jim Geifenberg
 3. (b) If veteran, name war no
 3. (c) Social Security No. None

4. Sex male 5. Color or race wh
 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 unknown
(Month) (Day) (Year)

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

9. Birthplace unknown
(City, town, or county) (State or foreign country)
 10. Usual occupation none

11. Industry or business _____
 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 Rev. W. J. Donald
 (b) Address my ave + main

17. (a) burial (b) Date thereof 7-26-45
(Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation St. Mary's

18. (a) Signature of funeral director Quib & Holm
 (b) Address 20 W. Raymond
 19. (a) 7-26-45 (b) Clara W. Seelye
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month July day 23
 year 1945 hour 5 minute 25 A. M.

21. I hereby certify that I attended the deceased from July 1, 45, to July 23, 19 45
 that I last saw him alive on July 23, 19 45
 and that death occurred on the date and hour stated above.

Immediate cause of death intertrochanteric fracture
left femur
Bronchopneumonia
 Due to _____

Due to _____
 Other conditions 1860-5
(Include pregnancy within 3 months of death)

Major findings: see above
 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) Accident 123
 (b) Date of occurrence 7-1-45

(c) Where did injury occur? K. C. Jackson Mo.
(City or town) (County) (State)
 (d) Did injury occur in or about home, on farm, in industrial place, in public place?
Home
(Specify type of place)
 While at work? No (e) Means of injury Fall

23. Signature Clark W. Seelye (M. D. or other) _____
 Address Med. Dir. K. C. General Hospital _____
Date used

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

MOTHER FATHER

7-24-45

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 *Dexter L. Kerley*.....

Licensed Embalmer No. *4225*.....

P. O. Address *Indep. 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.