

No. 2
M-543
5-17-39
I X36671

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

23241

FILED JUL 17 1945

Registration District No. 149

Primary Registration District No. 1002

State File No.

Registrar's No.

2782

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:
4123 Euclid
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community lifetime
years, months or days

3. (a) PRINT FULL NAME Mrs. Sophia A. Sulzer
3. (b) If veteran, name war no 3. (c) Social Security No. none

4. Sex Female 5. Color or race Wh 6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife Frank X. Sulzer 6. (c) Age of husband or wife if alive 58 years
7. Birth date of deceased Aug. 29 1887
(Month) (Day) (Year)

8. AGE: Years 57 Months 10 Days 1 If less than one day _____ hr. _____ min.

9. Birthplace K. C. Mo (City, town, or county) (State or foreign country)
10. Usual occupation at home

MOTHER FATHER { 11. Industry or business _____
12. Name Edward Zimmerman
13. Birthplace Germany (City, town, or county) (State or foreign country)
14. Maiden name Anna Goepfer
15. Birthplace Indiana (City, town, or county) (State or foreign country)

16. (a) Informant Frank X. Sulzer
(b) Address 4123 Euclid

17. (a) burial (Burial, cremation, or removal) (b) Date thereof 7-5-45 (Month) (Day) (Year)
(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Mrs. E. Quirk
(b) Address 4316 Troost Ave

19. (a) 7-2-45 (Date received local registrar) (b) Geraldine Holmes (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Jackson 48
(c) City or town Kansas City 3
(If outside city or town limits, write "RURAL")
(d) Street No. 4123 Euclid 8
(If rural, give location) 0
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 6 day 30
year 45 hour 7 minute 15 A.M.

21. I hereby certify that I attended the deceased from 1938 to June 29, 1945
that I last saw h. av alive on June 29, 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Auricular fibrillation Duration 5 years
Due to Chronic myocarditis ? years

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

Major findings: Of operations 93d PHYSICIAN _____
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) Means of injury _____
23. Signature Otto F. Reisman (M. D. or other)
Address 1115 Grand ave Date signed June 30 45

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

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

Thomas B. Quirk

Licensed Embalmer No. *3173*

P. O. Address *15 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.