

7. S. No. 2
DOM-5-43
Rev. 5-17-39
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State File No. **22223**
Registrar's No. **2270**

FILED AUG 13 1945
Registration District No. **787**

Primary Registration District No. **1602**

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: 2629 Gillham
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution XX
(Specify whether years, months or days)

In this community 60 years
(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. 2629 Gillham
(If rural, give location)

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

If yes, name country _____

3. (a) PRINT FULL NAME JOSEPH ANTONE BRUNO WERR

3. (b) If veteran, name war No

3. (c) Social Security No. None

4. Sex Ma 5. Color or race Wh

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

6. (b) Name of husband or wife Dora M. Werr

6. (c) Age of husband or wife if alive 80 years

7. Birth date of deceased August 29 1864
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>80</u>	<u>11</u>	<u>2</u>	_____ hr. _____ min.

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

10. Usual occupation Accountant

11. Industry or business Jackson City Col. Office

12. Name No Record

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

14. Maiden name No Record

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

16. (a) Informant Mrs. Dora M. Werr

(b) Address 2629 Gillham Road

17. (a) Burial
(Burial, cremation, or removal)

(b) Date thereof 8-4-45
(Month) (Day) (Year)

(c) Place: burial or cremation Calvary

18. (a) Signature of funeral director J. W. Wagner

(b) Address Kansas City, Mo.

19. (a) 8-3-45
(Date received local registrar)

(b) Sheraldine Holmes
(Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. day 1st
year 1945 hour 9: minute 30 A. M.

21. I hereby certify that I attended the deceased from 6/29/45, 19, to 8/1/45, 19
that I last saw him alive on 8/1/45, 19
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral thrombosis

Due to _____

Due to 93 &

Other conditions Arteriosclerotic heart disease
(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 C. J. Smith
Address 1109 P. W. 314 Koo
Date 8/2/45

Dr. J. J. J. J.
Prof. H. H. H. H. 1109

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..... *Cecil R. Matthes*

Licensed Embalmer No. *3807*

P. O. Address *Kansas City, 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.