

S. No. 2
M-5-43
5-17-39
I X36671

FILED JUL 23 1945

State File No. _____

Registration District No. _____

Primary Registration District No. 1002

Registrar's No. 2927

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:
Mrs. Bates Convalescent Home, 4 3231 Prospect
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 1/2 Months
(Specify whether
In this community 59 Years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 48
(c) City or town Kansas City 3
(If outside city or town limits, write "RURAL")
(d) Street No. 2019 Swope Parkway 8
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No) 0
If yes, name country _____

3. (a) PRINT FULL NAME MRS. FREDRICKA WISHROPP

3. (b) If veteran, name war No 3. (c) Social Security No. None

4. Sex Female / 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Charles F. Wishropp 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased October 27th 1856
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
88 8 14 hr. min.

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

10. Usual occupation At Home

11. Industry or business _____

MOTHER FATHER { 12. Name John Kindt

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

14. Maiden name Unknown

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

16. (a) Informant Mrs. Frank C. Beck
(b) Address 2019 Swope Parkway

17. (a) Burial (b) Date thereof 7 / 13 / 1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Union Cemetery

18. (a) Signature of funeral director Freeman Mortuary & Chapel
(b) Address 104 West 42nd. Street

19. (a) 7-12-45 (b) Seraldine Holmes
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 11 th
year 1945 hour 14 minute 15 P. M.
21. I hereby certify that I attended the deceased from June 1st 1944
19 1 to July 11th 1945
that I last saw her alive on July 11th 1945
and that death occurred on the date and hour stated above.

Immediate cause of death _____
Generalized arteriosclerosis
Congestive heart failure
Bronchopneumonia

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 Eraine Sherwood (M. D. or other) _____
Address Pathologist Date signed 7-12-45

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

Dr. Dhemrean

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 Walter H. Erwin

Licensed Embalmer No. 4352

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.