

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED SEP 1 1945
STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____
Registrar's No. **3386**

Registration District No. **149**
Primary Registration District No. **1002**

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: **Menorah Hospital 1**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution. **5 days**
In this community **25 years**
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County **Jackson 48**
(c) City or town **Kansas City rural**
(If outside city or town limits, write "RURAL")
(d) Street No. **8808 Custer Trail 0**
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **CLYDE ALLEN HUTCHINS**
3. (b) If veteran, name war **NO**
3. (c) Social Security No. **71407-1737**

4. Sex **Male (1)** **5. Color or race** **White** **6. (a) Single, widowed, married, divorced** **Married**
6. (b) Name of husband or wife **Jane Y. Hutchins** **6. (c) Age of husband or wife if alive** **38 years**
7. Birth date of deceased **December 6 1902**
(Month) (Day) (Year)

8. AGE:
Years **42** Months **8** Days **4** If less than one day
hr. _____ min. _____

9. Birthplace **Rugby No. Dakota**
(City, town, or county) (State or foreign country)
10. Usual occupation **Express Messenger**

11. Industry or business **Railway Express Company**
12. Name **Charles T. Hutchins**
13. Birthplace **Holden Missouri 1**
(City, town, or county) (State or foreign country)
14. Maiden name **Elizabeth Dahl**
15. Birthplace **Norway 4**
(City, town, or county) (State or foreign country)

16. (a) Informant: **Jane Y. Hutchins**
(b) Address **8808 Custer Trail, KCMo.**

17. (a) Burial (b) Date that **Aug. 13, 1945**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation: **Mt. Moriah, KCMo**

18. (a) Signature of funeral director: **M. Stradler & Son**
(b) Address **344 N. 5th, K. C. K.**

19. (a) 8-13-45 (b) **Bessie Holmes**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **Aug** day **10**
year **45** hour **3** minute _____ M.
21. I hereby certify that I attended the deceased from **Aug 6**
1945 to **Aug 10** **1945**
that I last saw him alive on **August 10** **1945**
and that death occurred on the date and hour stated above.

Immediate cause of death: **Coronary occlusion with infarction**
Due to _____
Due to _____

Other conditions (Include pregnancy within 3 months of death) **94**
Major findings:
Of operations _____
Of autopsy _____

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 the place) _____
23. Signatur **Alfred...** (M. D. or other)
Address **1103 Grand** Day signed **8-13-45**

Duration **5 day**
PHYSICIAN
Underline the cause to which death should be charged statistically.

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

28
3
2

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.....

Matt M. Shradoff

Licensed Embalmer No. *4383*

P. O. Address *A. C. Co.*

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.

SEP 25 1945