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ev. 5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED OCT 1 1945

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

29623
State File No.
Registrar's No. 3872

Registration District No. 149 Primary Registration District No. 10 02

1. PLACE OF DEATH:
(a) County Jackson
(b) City or town K.C.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 547 1/2 Main
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution
In this community unknown (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Jackson 48
(c) City or town K.C. 8
(If outside city or town limits, write "RURAL")
(d) Street No. 547 1/2 Main 8
(If rural, give location)
(e) Citizen of foreign country? unknown (Yes or No) 0
If yes, name country

3. (a) PRINT FULL NAME CHARLES DEWEY
3. (b) If veteran, name war Unknown
3. (c) Social Security No. Unknown
4. Sex M C
5. Color or race W
6. (a) Single, widowed, married, divorced Unknown
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 app 82. Months Days If less than one day hr. min.
9. Birthplace (City, town, or county) (State or foreign country) 9
10. Usual occupation
11. Industry or business
MOTHER FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country) 9
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country) 9
16. (a) Informant Coroners Office
(b) Address K-Co Mo.
17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 9/18/45 (Month) (Day) (Year)
(c) Place: burial or cremation Mt Calvary K C Kans
18. (a) Signature of funeral director Sebbeto's
(b) Address 901 E 5th
19. (a) 9-19-45 (Date received local registrar) (b) Geraldine Holmes (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 9 day 15 year 1945 hour 6:00 minute P M.
21. I hereby certify that I attended the deceased from Coroner, 19 , to , 19 ; that I last saw h alive on , 19 ; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Coronary sclerosis	
Due to: Lung sclerosis	
Due to:	
Other conditions (Include pregnancy within 3 months of death): 94a	

Major findings:
Of operations
Of autopsy no
History + Injection

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? (Specify type of place)
While at work? (e) Means of injury
23. Signature Jerome Waller (M. D. ~~or other~~)
Address 1424 Ind Bldg Date signed 9-17-45

(Licensed Embalmer's Statement on Reverse Side)

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.....

Licensed Embalmer No.....

P. O. Address.....

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.