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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 29686

FILED OCT 8 1945

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 3934

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: General Hospital 0
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 weeks (Specify whether
In this community 4 yrs 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. 2403 Rochester 8
(If rural, give location)
(e) Citizen of foreign country? 0 (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME John ~~Handshin~~ Handschin

3. (b) If veteran, name war no

3. (c) Social Security No. no

4. Sex Male 0

5. Color or race White

6. (a) Single, widowed, married, divorced Married 1

6. (b) Name of husband or wife Rosina Handschin

6. (c) Age of husband or wife if alive 79 years

7. Birth date of deceased Nov 4 - 1864 (Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
80	10	19	hr. min.

9. Birthplace Switzerland 5 (City, town, or county) (State or foreign country)

10. Usual occupation Retired

11. Industry or business Boilermaker

FATHER
12. Name George Handschin
13. Birthplace Switzerland 5 (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name No Record
15. Birthplace No Record a (City, town, or county) (State or foreign country)

16. (a) Informant Rosina Handschin
(b) Address 2403 Rochester

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept-26-1945 (Month) (Day) (Year)
(c) Place: burial or cremation Green Lawn

18. (a) Signature of funeral director Mrs C. L. Forster
(b) Address 918 Brooklyn

19. (a) 9-24-45 (Date received local registrar) (b) Geraldine Holmes (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month September 22 day
year 1945 hour 7 minute 20 P M.

21. I hereby certify that I attended the deceased from September 10, 1945 to September 22, 1945
that I last saw him alive on September 22, 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Intertrochanteric fracture left femur, bronchopneumonia coronary sclerosis with myocarditis

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations 1864 a-5 18

Of autopsy see above

Duration

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) accident 123
(b) Date of occurrence 9.9.45
(c) Where did injury occur? Kansas City Mo Jackson (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? home (Specify type of place)
While at work? no (e) Means of injury Fell

23. Signature Clark W Seeley M.D. (A.D. or other)
Address Med. Dir. K.C. General Hospital (Date signed)

(Licensed Embalmer's Statement on Reverse Side)

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. 3414

P. O. Address 918 Brooklyn

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.