

7. S. No. 2
DOM-5-43
Rev. 5-17-39
I X3687

FILED NOV 26 1945

State File No. _____
Registrar's No. 4645

Registration District No. _____ 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: General Hospital No. 10
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 Days
(Specify whether years, months or days)

In this community 25 Years
(Specify whether 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. 1719 Prospect
(If rural, give location)

(e) Citizen of foreign country? 0 (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Orlen Detrick

3. (b) If veteran, name war World war 1

3. (c) Social Security No. 487-12-3942

4. Sex Male 5. Color or race White

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

6. (b) Name of husband or wife Bessie Detrick

6. (c) Age of husband or wife if alive 35 years

7. Birth date of deceased 9 12 1890
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

55	1	27	hr. _____ min.
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9. Birthplace South Dakota
(City, town, or county) (State or foreign country)

10. Usual occupation Invalid

11. Industry or business _____

MOTHER FATHER {

12. Name Een Detrick

13. Birthplace No Record
(City, town, or county) (State or foreign country)

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

15. Birthplace No Record
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Bessie Detrick

(b) Address 5118 Cleveland

17. (a) Burial (b) Date thereof 11-12-1945
(Burial, cremation, or removal) (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) 11-10-45 (b) Geraldine Holmes
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 9
year 1945 hour 11 minute P. M.

21. I hereby certify that I attended the deceased from Nov. 9 1945 to Nov. 9 1945
that I last saw him alive on Nov. 9 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Bronchopneumonia

Due to _____

Due to _____

Other conditions 107
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____

Of autopsy See above

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)

(c) Means of injury _____

23. Signature Clark W. Seely M. D. or other _____
Address Med. Dir. Gen'l Hosp. Date signed 11-10-45

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

DEC 1 1945

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.....

C. H. Wise

Licensed Embalmer No.

2570

P. O. Address.....

100 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.