

S. No. 2  
DM-5-43  
v. 5-17-39  
I X36671

DEPARTMENT OF HEALTH OF THE STATE OF MISSOURI  
BUREAU OF THE VITALS  
STANDARD CERTIFICATE OF DEATH

State File No. **36303**  
Registrar's No. **4666**

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

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

**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**  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution **4 days**  
(Specify whether  
 In this community **4 months**  
years, months or days)

**2. USUAL RESIDENCE OF DECEASED:**  
 (a) State **Illinois** (b) County **Cook** **999**  
 (c) City or town **Chicago** **!!**  
(If outside city or town limits, write "RURAL")  
 (d) Street No. **2202 W. 112 St**  
(If rural, give location)  
 (e) Citizen of foreign country? **2**  
(Yes or No)  
 If yes, name country \_\_\_\_\_

**3. (a) PRINT FULL NAME** **HERBERT F. MERCEAU**  
**3. (b) If veteran,** name war **W.W.2** **3. (c) Social Security** No. **none**  
**4. Sex** **M** **5. Color or race** **W** **6. (a) Single, widowed, married, divorced** **single**  
**6. (b) Name of husband or wife** \_\_\_\_\_ **6. (c) Age of husband or wife if** \_\_\_\_\_  
alive years \_\_\_\_\_  
**7. Birth date of deceased.** **10 15 19 23**  
(Month) (Day) (Year)

**MEDICAL CERTIFICATION**  
**20. DATE OF DEATH:** Month **11** day **12**  
 year **1945** hour **3:30** minute **2** M.  
**21. I hereby certify that I attended the deceased from** \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;  
 that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_;  
 and that death occurred on the date and hour stated above.

**8. AGE:** Years **22** Months **0** Days **27** If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

**21. Immediate cause of death.**  
**Fractured Skull**  
**Fractured (Compound) Right Femur + Right Tibia + Fibula**  
**Due to Auto Traumatism**  
 Other conditions **Auto + parked car**  
(Include pregnancy within 3 months of death)

**9. Birthplace.** **Chicago Ill**  
(City, town, or county) (State or foreign country)  
**10. Usual occupation.** **Mariner**

**Major findings:** **190C-8**  
**Of operations.** **1727**  
**Of autopsy.** **no history + impetum**  
**PHYSICIAN**  
 Underline the cause to which death should be charged statistically.

**11. Industry or business.**  
**12. Name.** **Franz R. Merceau**  
**13. Birthplace.** **Illinois**  
(City, town, or county) (State or foreign country)  
**14. Maiden name.** **unknown**  
**15. Birthplace.** **unknown** **9**  
(City, town, or county) (State or foreign country)

**22. If death was due to external causes, fill in the following:**  
 (a) Accident, suicide, or homicide (specify) **accident** **123**  
 (b) Date of occurrence **11-12-45**  
 (c) Where did injury occur? **Every Blvd + Wormal St. John Ill**  
(City or town) (County) (State)  
 (d) Did injury occur in or about home, on farm, in industrial place, in public place?  
 While at work? **no** **(Specify type of place)**  
 (e) Means of injury **automobile**  
**Signature** **Jeanne Walker** **(M.D. or other)**  
**Address** **1424 1/2 St** **Date signed** **11-12-45**

**16. (a) Informant.** **K.A. Rindflesh**  
**(b) Address.** **U S N A S Olathe Kans**  
**17. (a) Burial** **(b) Date thereof.** **11-12-45**  
(Burial, cremation, or removal) (Month) (Day) (Year)  
**(c) Place: burial or cremation.** **Chicago Ill**  
**18. (a) Signature of funeral director.** **Stine & McClure**  
**(b) Address.** **Kansas City Mo**  
**19. (a) 11-12-45** **(b) Geraldine Holmes**  
(Date received local registrar) (Registrar's signature)

**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..... *Robert H Reed*.....  
Licensed Embalmer No. *3745*.....  
P. O. Address..... *N. C. 710*.....

**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.**