

S. No. 2
00M-5-43
Rev. 5-17-39
I X38671

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 36317
4652
Registrar's No. _____

FILED NOV 26 1945
Registration District No. _____

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 No. 1
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 7 days
(Specify whether years, months or days)

In this community 3 years

3. (a) PRINT FULL NAME Glenn Wesley Muzny

3. (b) If veteran, name war XX no 3. (c) Social Security No. none

4. Sex Ma 5. Color or race Wh 6. (a) Single, widowed, married, divorced sgl

6. (b) Name of husband or wife XX 6. (c) Age of husband or wife if alive XX years

7. Birth date of deceased December 10 1939
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>5</u>	<u>11</u>	<u>0</u>	hr. _____ min.

9. Birthplace Prague Okla
(City, town, or county) (State or foreign country)

10. Usual occupation XX Child

11. Industry or business

12. Name Wesley Muzny

13. Birthplace Prague Okla
(City, town, or county) (State or foreign country)

14. Maiden name Marie Wade

15. Birthplace Cypress Texas
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Marie Muzny

(b) Address 1340 East 8th St.

17. (a) Removal Removal (b) Date thereof 11-12-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Prague, Okla.

18. (a) Signature of funeral director J.W. Wagner

(b) Address Kansas City, Mo.

19. (a) 11-10-45 (b) Sheraldine Holmes
(Date received local registrar) (Registrar's signature)

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. 1340 E. 8th
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November day 10th
year 1945 hour 8:00 minute 20 P.M.

21. I hereby certify that I attended the deceased from 11-3, 1945 to 11-10, 1945
that I last saw him alive on 11-10, 1945; and that death occurred on the date and hour stated above.

Immediate cause of death Diphtheria with complicating myocarditis

Due to _____

Due to _____

Other conditions 10
(Include pregnancy within 3 months of death)

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 type of place)

(c) Means of injury _____

23. Signature Link W. Seely (M.D. or other)
Address Gen. Hosp. #1 Date signed _____

Duration _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

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 Alvin R. Gausefeld

Licensed Embalmer No. 415-9

P. O. Address Kansas City 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.