

S. No. 2
FORM-5-43
Rev. 5-17-39
I X36671

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

36384

State File No. _____

FILED DEC 12 1945
Registration District No. 199

Primary Registration District No. 1002

Registrar's No. 4883

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:
921 East 79 St Terrace
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____
In this community 2 years (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 48

(c) City or town Kansas City
(If outside city or town limits, write "RURAL")

(d) Street No. 921 East 79 St Terrace
(If rural, give location)

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

3. (a) PRINT FULL NAME Phillip Segele

3. (b) If veteran, name war None

3. (c) Social Security No. none

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. 26 day 1945
year 1945 hour 12:30 minute A M.

4. Sex Male

5. Color or race White

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

6. (b) Name of husband or wife Elizabeth Segele

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

7. Birth date of deceased July 4 1863
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;

that I last saw him alive and that death occurred on the date and hour stated above.

8. AGE:

Years	Months	Days	If less than one day
<u>82</u>	<u>4</u>	<u>22</u>	hr. _____ min. _____

Immediate cause of death Coronary sclerosis

Due to status sclerosis

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

10. Usual occupation Retired

Other conditions 9/1a
(Include pregnancy within 3 months of death)

Major findings: _____

MOTHER FATHER {

11. Industry or business Street Ry Service

12. Name Segele

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

14. Maiden name Elizabeth Arnett

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

PHYSICIAN

Underline the cause to which death should be charged statistically.

Of autopsy Histology & Biopsy

16. (a) Informant Mattie Reinhardt

(b) Address 921 East 79 St Terrace

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 27 1945
(Month) (Day) (Year)

(c) Place: burial or cremation Blmwood Cem.

18. (a) Signature of funeral director Mrs C.L. Forster

(b) Address 918 Brooklyn

19. (a) 11-27-45 (Date received local registrar) (b) Deraldine Holmes (Registrar's signature)

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) (e) Means of injury _____

Signature [Signature] (M. D. or other) Date signed 11-26-45

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.....

Joe B. Yoder

Licensed Embalmer No. *4173*

P.O. Address *918 Brooklyn*

K.C. 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.