No. 2
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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. 39986

FILED DEC 28 1945

Registration District No. 149 Primary Registration District No. 1802 Registrar's No. 5090

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 1 mo. 24 days (Specify whether
In this community twenty years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 47

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

(d) Street No. 613 Main
(If rural, give location)

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

If yes, name country

3. (a) PRINT FULL NAME William Addis

3. (b) If veteran, name war no

3. (c) Social Security No. none

4. Sex Male

5. Color or race White

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

6. (b) Name of husband or wife unknown

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

7. Birth date of deceased Not known
(Month) (Day) (Year)

8. AGE: Years 74 | Months | Days | If less than one day hr. min.

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

10. Usual occupation Not known

11. Industry or business Not known

FATHER
12. Name Henry Addis
13. Birthplace (City, town, or county) Ireland (State or foreign country)

MOTHER
14. Maiden name Not known
15. Birthplace (City, town, or county) Not known (State or foreign country)

16. (a) Informant Record Clerk

(b) Address K. C. General Hospital No. 1

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-13-45 (Month) (Day) (Year)

(c) Place: burial or cremation Leeds

18. (a) Signature of funeral director Wm A Lohmeyer

(b) Address City Mortician

19. (a) 12-11-45 (Date received local registrar) (b) Geraldine Holmes (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 14
year 1945 hour 4 minute 15 A. M.

21. I hereby certify that I attended the deceased from Sept. 21, 1945 to Nov. 14, 1945; that I last saw him alive on Nov. 14, 1945; and that death occurred on the date and hour stated above.

Immediate cause of death Bronchopneumonia

Due to Intertrochanteric fracture of left femur

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy None

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) Sept. 21, Accident

(b) Date of occurrence Sept. 21, 1945 123

(c) Where did injury occur? K. C. Jackson, Mo.
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? Sidewalk
(Specify type of place)

While at work? No (e) Means of injury Fall

23. Signature Clark W Seely MD (M. D. or other)

Address Med. Dir. Gen'l Hosp. Date signed 11-15-45

(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 Not Embalmed, Registered Apprentice No. ....., working under my personal supervision.

Signed Wm A Lohmeyer

Licensed Embalmer No. 3089

P. O. Address KC 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.