

FILED JAN 9 1945
Registration District No. 199

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 Kansas City Tuberculosis Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 61 days
(Specify whether
In this community 20 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson **48**
(c) City or town Kansas City **3**
(If outside city or town limits, write "RURAL")
(d) Street No. 5120 Michigan **8**
(If rural, give location)
(e) Citizen of foreign country? No **0**
(Yes or No)
If yes, name country: ---

3. (a) PRINT FULL NAME Guy Rutherford Switzer

3. (b) If veteran, name war No 3. (c) Social Security No. 486-26-8876

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Divorced
6. (b) Name of husband or wife MRS. 6. (c) Age of husband or wife if alive years
7. Birth date of deceased January 15 1891
(Month) (Day) (Year)

8. AGE: Years 54 Months 11 Days 2 If less than one day
br. min.

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

10. Usual occupation Messenger
11. Industry or business Western Union

MOTHER, FATHER { 12. Name Harry Seutger
13. Birthplace Lowell City Iowa
(City, town, or county) (State or foreign country)
14. Maiden name Henrietta Root
15. Birthplace McCune Kansas
(City, town, or county) (State or foreign country)

16. (a) Informant Record Clerk
(b) Address Kansas City Tuberculosis Hosp
17. (a) BURIAL (b) Date thereof DEC 20 1945
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation MEMORIAL PARK CEM.

18. (a) Signature of funeral director D. N. Henderson's Sons
(b) Address 1401-BRUSH GREEN BLVD.
19. (a) 12-18-45 (b) M. Geraldine Holmes
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 17
year 1945 hour 5 minute 45 P.M.

21. I hereby certify that I attended the deceased from 10-17-45, 1945, to 12-17-45, 1945
that I last saw him alive on 12-17-45, 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary Tuberculosis **1 year**
Duration

Due to _____
Due to _____

Other conditions 15
(Include pregnancy within 3 months of death)

Major findings: Of operations _____
Of autopsy _____
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)
(e) Means of injury _____
23. Signature A. L. Coffman M.D.
Address Kansas City Mo Date signed 12-17-45

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

Melvin Miller

Licensed Embalmer No. *4407*

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.