S. No. 2
M—5-43
5-17-39
I X36671

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

FILED APR 17 1946

State File No. 13403

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 1614

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

12309

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: 6632 TRACY AVENUE 1
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ---- (Specify whether
In this community MARGARET LIFE TIME
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. 6632 TRACY AVENUE 8
(If rural, give location)

(e) Citizen of foreign country? NO (Yes or No) 0

If yes, name country ----

3. (a) PRINT FULL NAME MARGARET ISABEL WECKMAN TREAT

3. (b) If veteran, name war NO

3. (c) Social Security No. NONE

4. Sex FEMALE

5. Color or race WHITE

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

6. (b) Name of husband or wife MR JAMES A. TREAT.

6. (c) Age of husband or wife if alive 34 years

7. Birth date of deceased JULY (Month) 22 (Day) 1909 (Year)

8. AGE: Years 36 Months 8 Days 10 If less than one day ___ hr. ___ min.

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

10. Usual occupation AT HOME

11. Industry or business HOUSE WIFE

FATHER
12. Name FRED. WILLIAM WECKMAN
13. Birthplace LADDIE (City, town, or county) IOWA (State or foreign country)

MOTHER
14. Maiden name FRANCES M. SCHILLER
15. Birthplace CARROLLTON (City, town, or county) MISSOURI (State or foreign country)

16. (a) Informant MR JAMES COUNTON TREAT

(b) Address 6632 TRACY AVENUE

17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof APR-4-1946 (Month) (Day) (Year)

(c) Place: burial or cremation MEMORIAL PARK CEM.

18. (a) Signature of funeral director D. W. Newcomer Sons

(b) Address 1401 BRUSH CREEK BLVD.

19. (a) 4-4-46 (Date received local registrar) Geraldine Holmes (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month APRIL day 2 ND. year 1946 hour 5 minute 30 P. M.

21. I hereby certify that I attended the deceased from June, 1945, to April 2, 1946 that I last saw her alive on April 2, 1946 and that death occurred on the date and hour stated above.

Immediate cause of death Mitral regurgitation & Aortic regurgitation

Due to Rheumatic heart disease Chronic

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations 92 K

Of autopsy

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)

(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? (Specify type of place)

While at work? (e) Means of injury 0

23. Signature A. J. Spaffard (M. D. ~~or other~~)

Address Kansas City Mo Date signed 4-3-46

(Licensed Embalmer's Statement on Reverse Side)

223 Argyle Bldg.
1-5-30

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 Earl Rapp

Licensed Embalmer No. 3458

P. O. Address 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.