

U. S. No. 2
DOM-5-43
Rev. 5-17-39
I X3667

FILED JUL 31 1946

Registration District No. 149

Primary Registration District No. 1002

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 2 days
(Specify whether years, months or days)

In this community 203 years
(Specify whether years, months or days)

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. 915 Paseo
(If rural, give location)

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

3. (a) PRINT FULL NAME Albert M. Aeils

3. (b) If veteran, name war World War # 2

3. (c) Social Security No. unknown

4. Sex Male

5. Color or race White

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

6. (b) Name of husband or wife Barbara Aeils

6. (c) Age of husband or wife if alive 25 years

7. Birth date of deceased December 27, 1922
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>23</u>	<u>6</u>	<u>22</u>	hr. _____ min. _____

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

10. Usual occupation Clerk

11. Industry or business Faeth Hardware Company.

MOTHER FATHER { 12. Name Albert A. Aeils

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

14. Maiden name Edith Mary Stout

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

16. (a) Informant Mrs. Barbara Aeils

(b) Address 915 Paseo, K.C. Mo.

17. (a) Burial
(Burial, cremation, or removal)

(b) Date thereof 7-20-46
(Month) (Day) (Year)

(c) Place: burial or cremation mt. St. Marys

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

(b) Address 918-20 Brooklyn, K.C. Mo.

19. (a) 7-20-46 (b) Geralline Holme
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 19
year 1946 hour 4 minute A. M.

21. I hereby certify that I attended the deceased from July 17 1946 to July 19 1946
that I last saw him alive on July 19 1946
and that death occurred on the date and hour stated above.

Immediate cause of death Acute anterior poliomyelitis

Due to _____

Due to _____

Other conditions 36
(Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy See above

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 Wm W. Hard (M. D. or other) MD
Address Med. Dir. Gen'l Hosp. Date signed 7-19-46

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

Dr. Buckner

OCT 17 1947

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: *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.