

S. No. 2  
-12-45  
5-17-39  
PI X47070

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **1073**  
Registrar's No. **141**

FILED JAN 20 1947

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: Home 2920 Flora!  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
In this community 64 Years (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Mo (b) County Jackson  
(c) City or town Kansas City (If outside city or town limits, write "RURAL")  
(d) Street No. 2920 Flora (If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME James M. Engel  
3. (b) If veteran, name war No 3. (c) Social Security No. No

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month Jan. day 9th. year 1947 hour 6 minute 30A M.  
21. I hereby certify that I attended the deceased from April 30, <sup>1943</sup> to January 9, 1947.  
that I last saw him alive on April 9, 1947; and that death occurred on the date and hour stated above.

4. Sex Male 5. Color or race Wh.  
6. (a) Single, widowed, married, divorced Wid.  
6. (b) Name of husband or wife Unknown 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased Jan. 15 1877  
(Month) (Day) (Year)

Immediate cause of death Hypertensive Heart Disease Duration \_\_\_\_\_  
Due to Hypertension  
Due to \_\_\_\_\_  
Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

8. AGE: Years 70 Months 69 Days 24 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation Book Binder

11. Industry or business \_\_\_\_\_  
12. Name Henry Engle  
13. Birthplace Germany  
(City, town, or county) (State or foreign country)  
14. Maiden name Elizabeth Koelsch  
15. Birthplace Germany  
(City, town, or county) (State or foreign country)

PHYSICIAN  
Major findings: ap. d.  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

16. (a) Informant Mrs. M. Kiekbush  
(b) Address 2920 Flora

17. (a) Burial (b) Date thereof Jan 11 47  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Memorial Park  
Wornall Funeral Home

18. (a) Signature of funeral director \_\_\_\_\_  
(b) Address 7406 Wornall Rd.

19. (a) 1-11-47 (b) Geraldine Holmes  
(Date received local registrar) (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) (a) Means of injury \_\_\_\_\_  
23. Signature George O. Jones (M. D. or other) M.D.  
Address 1103 Grand Ave. K. C. Mo Date signed 1/10/47

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

MOTHER FATHER

**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.....

*Howard J. Roe*

Licensed Embalmer No.....

*2748*

P. O. Address.....

*2 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.