

S. No. 2
M-5-43
v. 5-17-39
I X36671

Registration District No. 149 Primary Registration District No. 1002

1. PLACE OF DEATH:
(a) County Jackson
(b) City or town Kansas City
(c) Name of hospital or institution: Little Sisters of the Poor 5
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution no. 3 mos. 20 days
(Specify whether years, months or days)

3. (a) PRINT FULL NAME George C. Fenner
3. (b) If veteran, name war no.
3. (c) Social Security No. no.

4. Sex male 0
5. Color or race white
6. (a) Single, widowed, married, divorced single
6. (b) Name of husband or wife X
6. (c) Age of husband or wife if alive X years
7. Birth date of deceased unknown.
(Month) (Day) (Year)

8. AGE: Years 79 Months unknown Days If less than one day hr. min.

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

10. Usual occupation Retired

11. Industry or business X

MOTHER FATHER
12. Name William Fenner 9
13. Birthplace unknown (City, town, or county) (State or foreign country)
14. Maiden name Mary Toole 1
15. Birthplace unknown (City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Samuel Stewart
(b) Address 333 W. 46th Ter., Kansas City, Mo.
17. (a) burial (b) Date thereof 1-22-47
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Atchison, Kansas

18. (a) Signature of funeral director Stine & McClure
(b) Address 3235 Gillham Plaza, K. C., Mo.
19. (a) 1-22-47 (b) Geraldine Holmes
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Jackson HK
(c) City or town Kansas City 3
(If outside city or town limits, write "RURAL") 8
(d) Street No. 5300 Highland 0
(If rural, give location)
(e) Citizen of foreign country? no. (Yes or No)
If yes, name country. X

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month January day 20
year 1947 hour 5:30 minute P. M.
21. I hereby certify that I attended the deceased from Jan 10
to Jan 20 1947.
that I last saw him alive on Jan 18 1947
and that death occurred on the date and hour stated above.

Immediate cause of death
Cardiac failure
arteriosclerosis & nephritis
Due to 10 days
13/2
Other conditions (Include pregnancy within 3 months of death)
Major findings: Of operations no
Of autopsy no
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 John T. Springer (M. D. or other) MD
Address 1022 Main Ave Date signed 1-21-47
K. E. MO

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

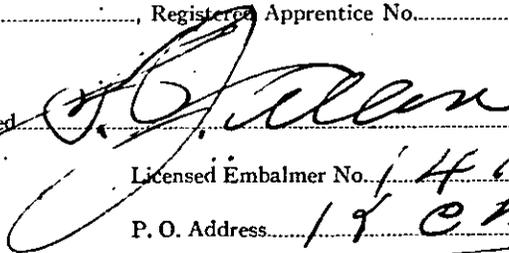
Dr. John T. Skinner, Bryant Bldg.,

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


.....

Licensed Embalmer No. 1465

P. O. Address 19 e m

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.