S. No. 2
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED APR 8 1947

Registration District No. 197

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 1002

State File No. 9304

Registrar's No. 1368

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: 4
Nora-Rae Restorium 309 Garfield
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 4 months (Specify whether
In this community 45 Years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 47

(c) City or town Kansas City 3
(If outside city or town limits, write "RURAL")

(d) Street No. 4911 Bellefontaine 8
(If rural, give location)

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

If yes, name country

3. (a) PRINT FULL NAME MRS. KATHERINE OSTERMANN

3. (b) If veteran, name war xx

3. (c) Social Security No. None

4. Sex FEMALE 1

5. Color or race WHITE

6. (a) Single, widowed, married, divorced Widowed 21

6. (b) Name of husband or wife Carl Ostermann

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

7. Birth date of deceased December (Month) 12 (Day) ~~1883~~ 1884 (Year)

8. AGE: Years 62 ~~63~~ Months 3 Days 10 If less than one day hr. min.

9. Birthplace Illinois (City, town, or county) (State or foreign country) 1

10. Usual occupation At Home

11. Industry or business

FATHER
12. Name Wm. Schmidt 4
13. Birthplace (City, town, or county) Germany (State or foreign country) 1

MOTHER
14. Maiden name No Record 9
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant Carl Ostermann
(b) Address 4911 Bellefontaine

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-25-47 (Month) (Day) (Year)
(c) Place: burial or cremation Mt. Moriah Cemetery

18. (a) Signature of funeral director J W Wagner
(b) Address Kansas City, Mo.

19. (a) 3-24-47 (Date received local registrar) (b) Geraldine Holmes (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 22
year 1947 hour 11 minute 45 P.M.

21. I hereby certify that I attended the deceased from November 20, 1946, to March 22, 1947
that I last saw her alive on March 22, 1947
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Cardiac failure	2 days
Due to myocardial decompensation	unknown
Due to	
Other conditions Diabetes mellitus (Include pregnancy within 3 months of death) Chronic nephritis	unknown

Major findings:
Of operations 61
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?
(Specify type of place) 2
While at work? (e) Means of injury

23. Signature Helen M Henery (M. D. or other) Do
Address 205 Garfield Date signed 3/23/47

(Licensed Embalmer's Statement on Reverse Side)

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. Alvin R Haunschild

Licensed Embalmer No. 4159

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.