

FILED MAY 5 1947
 149

Registration District No. _____

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:
3829 Brooklyn /
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
(Specify whether
 In this community 30 years
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. 3829 Brooklyn 8
(If rural, give location) 0
 (e) Citizen of foreign country? no (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 25th
 year 1947 hour 12 minute 50 P. M.
 21. I hereby certify that I attended the deceased from March 12th
1947, to April 25th 1947;
 that I last saw her alive on April 24th 1947;
 and that death occurred on the date and hour stated above.
 Immediate cause of death Carcinoma of lung Duration

Due to Haemorrhage from
the above.
 Due to _____
 Other conditions Bronchitis
(Include pregnancy within 3 months of death)

Major findings:
 Of operations none
 Of autopsy none
 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 0
 (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? _____ Means of injury 0
 23. Signature Paul R. Johnson (M. D. or other) MD
 Address 3011 A. Indep. Ave. Date signed 4/26/47

3. (a) PRINT FULL NAME OLLIE WOLF MIEHE

3. (b) If veteran, name war - no 3. (c) Social Security No. none

4. Sex fe 5. Color or race white 6. (a) Single, widowed, married, divorced wid 2

6. (b) Name of husband or wife August 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased April 7 1869
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>78</u>	<u>0</u>	<u>18</u>	____ hr. ____ min.

9. Birthplace Cameron Mo 0
(City, town, or county) (State or foreign country)

10. Usual occupation Invalid

11. Industry or business at home

12. Name Unknown 9

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

14. Maiden name unknown

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

16. (a) Informant Dr. E. A. Mische

(b) Address 1127 White

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-28-47
(Month) (Day) (Year)

(c) Place: burial or cremation Cameron Mo.

18. (a) Signature of funeral director C.H. Blackman & Son, Inc.

(b) Address 2825 Independence Blvd.

19. (a) 4-26-47 Geraldine Holmes
(Date received local Registrar) (Registrar's signature)

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.....

J. H. Blackman

Licensed Embalmer No.....

3639

P. O. Address.....

14 C. 760

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.