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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 13709

FILED MAY 5 1947

Registration District No. 999 Primary Registration District No. 1002 Registrar's No. 1815

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: Muehlebach Hotel
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 24 Hours (Specify whether
In this community 24 Hours
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State W Virginia (b) County 999

(c) City or town Parkersburg 46
(If outside city or town limits, write "RURAL")

(d) Street No. 0
(If rural, give location)

(e) Citizen of foreign country? no (Yes or No) 2

If yes, name country

3. (a) PRINT FULL NAME CHARLES H TREAT

3. (b) If veteran, name war none

3. (c) Social Security No. none

4. Sex Male 0

5. Color or race White

6. (a) Single, widowed, married, divorced Married 1

6. (b) Name of husband or wife Murial Treat

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

7. Birth date of deceased Dec 16 1902
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
44	4	3	hr. min.

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

10. Usual occupation Retired

11. Industry or business

FATHER
12. Name Fredrick Treat
13. Birthplace Boston Mass 1
(City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Mary Leonard
15. Birthplace Boston Mass 1
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs Clare Treat Morse
(b) Address South Bend Indiana

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 4/20/47 (Month) (Day) (Year)
(c) Place: burial or cremation Boston Mas

18. (a) Signature of funeral director Fuerk and Tobin
(b) Address 20 West Linwood

19. (a) 4-21-47 (Date received local registrar) (b) Geraldine Holmes (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 19th day April
year 1947 hour 3:30 minute A M.

21. I hereby certify that I attended the deceased from Coroner, 19, to , 19;
that I last saw h alive on , 19;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Fracture of skull. Fracture of neck.	
Due to Crushed Chest.	
Due to	
Other conditions (Include pregnancy within 3 months of death) 164	
Major findings: Of operations	
Of autopsy no History & Inquiry	

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) Suicide

(b) Date of occurrence 4-19-47

(c) Where did injury occur? KC. Jackson mo
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
public place
(Specify type of place)

While at work? no (e) Means of injury Fall 3

23. Signature James C Walker (M. D. or other) Coroner

Address 1424 [illegible] Date signed 4-21-47

(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 Howard W. Farmer

Licensed Embalmer No. 4134

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.