

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: **St. Mary's Hospital**
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution: **Hospital 2 days**
(Specify whether
 In this community **2 days**
years, months or days)

3. (a) PRINT FULL NAME **William E. Gaffron**

3. (b) If veteran, name war **no** 3. (c) Social Security No. **unknown**

4. Sex **Male** 5. Color or race **White** 6. (a) Single, widowed, married, divorced. **Married**

6. (b) Name of husband or wife **Marcella Gaffron** 6. (c) Age of husband or wife if alive **72** years

7. Birth date of deceased **Oct. 3 1874**
(Month) (Day) (Year)

8. AGE: Years	Months	Days	If less than one day
72	7	7	hr. _____ min.

9. Birthplace **Jefferson City - Missouri**
(City, town, or county) (State or foreign country)

10. Usual occupation **Carman Foreman Retired**

11. Industry or business **Nickel Plate**

12. Name **William Gaffron**

13. Birthplace **Unknown Germany**
(City, town, or county) (State or foreign country)

14. Maiden name **Margaret Christ**

15. Birthplace **Unknown Germany**
(City, town, or county) (State or foreign country)

16. (a) Informant **Marcella Gaffron**

(b) Address **538 Veronica Ave., E. St. Louis**

17. (a) **Removal** (b) Date thereof **5 11 47**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Exxs. E. St. Louis Ill**

18. (a) Signature of funeral director **John Stout**

(b) Address **340 N. 6th St. K.C.K.**

19. (a) **5-11-47** **L. Geraldine Helms**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Illinois** (b) County **St. Clair**
 (c) City or town **E. St. Louis**
(If outside city or town limits, write "RURAL")
 Street No. **538 Veronica Ave**
(If rural, give location)
 (e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **May** day **10**
 year **1947** hour **3** minute **10** P.M.

21. I hereby certify that I attended the deceased from **5 8 1947** to **5 10 1947**
 that I last saw him alive on **5 5 1947**
 and that death occurred on the date and hour stated above.

Immediate cause of death **General hemiplegia**
 Duration _____

Due to **Hypertension**
 Due to _____

Other conditions **_____**
(Include pregnancy within 3 months of death)

Major findings:
 Of operations **83**
 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? _____

While at work? _____ (Specify type of place)
 (e) Means of injury **10**

23. Signature **J. W. Burke** (M. D. or other) **10**
 Address **Kens 63 Ave** Date signed **5/11/47**

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

JUN 18 1947
1947

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 Amelia Stiel

Licensed Embalmer No. 4113

P. O. Address Kansas City Kansas

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, above space should be left blank.