

S. No. 2
FORM-5-43
Rev. 5-17-39
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17656

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

Registrar's No.

FILED MAY 29 1947

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:
1400 Union Avenue
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community 40 years
years, months or days

3. (a) PRINT FULL NAME MOZE TURBOVICH
3. (b) If veteran, name war None
3. (c) Social Security No. none

4. Sex Male 5. Color or race White
6. (a) Single, widowed, married, divorced Single
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Unknown 1874
(Month) (Day) (Year)

8. AGE: Years 73 Months _____ Days _____ If less than one day _____ hr. _____ min.

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

10. Usual occupation Laborer

11. Industry or business _____

MOTHER FATHER

12. Name Turbovich
13. Birthplace Yugoslavia
(City, town, or county) (State or foreign country)
14. Maiden name Helen Gebba
15. Birthplace Yugoslavia
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Norte Boca

(b) Address 240 North 6th Street, K.C. Kan

17. (a) Burial (Burial, cremation or removal) (b) Date thereof 5-21-47
(Month) (Day) (Year)

(c) Place: burial or cremation Mt. Calvary: K.C. Kan

18. (a) Signature of funeral director Weilert Funeral Home

(b) Address Kansas City, Missouri

19. (a) 5-22-47 (Date received local registrar) (b) Sheldine Holmes (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Kansas (b) County Wyandotte
(c) City or town Kansas City
(If outside city or town limits, write "RURAL")
(d) Street No. 23 Central Avenue
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 14th
year 1947 hour 10:25AM minute _____ M.

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

Immediate cause of death Shock
Due to Fracture of Legs
Railroad Trauma
train + pedestrian
Other conditions 169-8
(Include pregnancy within 3 months of death)
Major findings Deputy Coroner
Of operations _____
Of autopsy Shock + Impaction
PHYSICIAN _____
Underline the cause to which death could be attributed.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) Accident
(b) Date of occurrence 5-14-47
(c) Where did injury occur? Kansas City
(City or town) (State)
(d) Did injury occur in or about home, on farm, in industrial place, or public place?

While at work? No (Specify type of place) (a) Means of injury Trauma
Signature A.E. Wasker (M. D. or other) MO
Address 2800 Main Date 5/19/47

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

48
3
8

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..... *Blaine E. Walcutt*

..... Licensed Embalmer No. *4075*

..... P. O. Address..... *K.C. 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.