

S. No. 2
M-5-43
5-17-39
I X36671

FILED AUG 7 1947

Registration District No. **147** Primary Registration District No. **1002**

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

1. PLACE OF DEATH:

(a) County **JACKSON**

(b) City or town **K.C. Mo.**
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
TRINITY LUTHERAN HOSPITAL
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **18 days**
(Specify whether years, months or days)

In this community **Lifetime**

3. (a) PRINT FULL NAME **MISS ELSA BAUKNECHT**

3. (b) If veteran, name war **No**

3. (c) Social Security No. **None**

4. Sex **F** 5. Color or race **W**

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

6. (b) Name of husband or wife

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

7. Birth date of deceased **June 25 1893**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

54 0 28 hr. min.

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

10. Usual occupation **At Home**

11. Industry or business _____

MOTHER FATHER

12. Name **August Bauknecht**

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

14. Maiden name **Elsa Boethe**

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

16. (a) Informant **Elmer H. Lawson**

(b) Address **4115 Prospect**

17. (a) **Burial** (b) Date thereof **7/25/47**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Memorial Park**

18. (a) Signature of funeral director **J. W. Wagner**

(b) Address **Kansas City Mo.**

19. (a) **7-24-47** (b) **Heraldine Holmes**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Jackson**

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

(d) Street No. **4115 Prospect**
(If rural, give location)

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

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **7** day **23**
year **47** hour **10** minute **25** P.M.

21. I hereby certify that I attended the deceased from **June 1, 1947** to **July 23, 1947**
that I last saw her alive on **July 23, 1947**
and that death occurred on the date and hour stated above.

Immediate cause of death **Cardiac Failure** Duration **3 weeks**

Due to **Hypertension**

Due to **Nephritis**

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations **131 a**

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? **0**

While at work? _____ (Specify type of place)

(e) Means of injury _____

23. Signature **Charles Stashed** M.D. or other **MD**

Address **1103 Grand** Date signed **7/24/47**

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..... *Cecil R. Matthes*

..... Licensed Embalmer No. *3807*

P. Of 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.