

National Office of Vital Statistics
FILED SEP 23 1947
Registration District No. **179**

Primary Registration District No. **1002**

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

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 **General Hospital No. 1 0**
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **21 days**
(Specify whether years, months or days)

In this community **2nd Stage 40 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. **510 E. 8 St.** **8**
(If rural, give location) **0**

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

If yes, name country _____

3. (a) PRINT FULL NAME **William Draper**

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

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Sept.** day **10**
year **1947** hour **12** minute **45 P.M.**

4. Sex **male** 5. Color **White**

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

6. (b) Name of husband or wife **unknown**

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

7. Birth date of deceased **Feb 17 - 1862**
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **Aug. 20**, 19**47** to **Sept. 10**, 19**47**
that I last saw him alive on **Sept. 10**, 19**47**
and that death occurred on the date and hour stated above.

Immediate cause of death **Acute coronary occlusion**

Duration _____

8. AGE:

Years	Months	Days	If less than one day
85	6	22	hr. min.

Due to _____

Due to _____

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

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

10. Usual occupation **none**

Major findings: Of operations _____

11. Industry or business _____

Of autopsy **See above**

12. Name **Wm Draper**

PHYSICIAN _____
Underline the cause of which death should be charged statistically.

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

14. Maiden name **Wm Wellington**

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

16. (a) Informant **Deirda Clark**

(b) Address **K. C. Gen Hosp**

17. (a) **Cremation** (b) Date there **Sept 11-47**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Elmwood**

18. (a) Signature of funeral director **Wm Beathmeyer**

(b) Address **City physician**

19. (a) **9-10-47** (b) **Seraldine Holmes**
(Date received local registrar) (Registrar's signature)

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 **0**

23. Signature **Wm W. Hart** (M. D. or other) **MD**

Address **Med. Dir. Gen'l Hosp** Date signed **9-10-47**

Dr. Anderson

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 _____

not Embalmed

Registered Apprentice No. _____

working under my personal supervision.

Signed *Wm A. Schuyler*

Licensed Embalmer No. *3089*

P. O. Address *KC 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.