

National Office of Vital Statistics  
FILED DEC 15 1947  
Registration District No. 149

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: R. GENERAL HOSPITAL No. 1 0  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 40 MINUTES  
(Specify whether years, months or days)

In this community 3 YEARS

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County JACKSON <sup>48</sup>

(c) City or town KANSAS CITY <sup>3</sup>  
(If outside city or town limits, write "RURAL")

(d) Street No. 3313 EAST 24TH ST TERRACE <sup>8</sup>  
(If rural, give location) <sup>0</sup>

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

If yes, name country

3. (a) PRINT FULL NAME MRS. MARY KATHERINE WANGLER

3. (b) If veteran, No name war

3. (c) Social Security No. none

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month NOVEMBER day 30<sup>TH</sup>  
year 1947 hour 7 minute 30 P. M.

4. Sex FEMALE 5. Color or race WHITE

6. (a) Single, widowed, married, divorced MARRIED

6. (b) Name of husband or wife MR. HOMER WANGLER

6. (c) Age of husband or wife if alive 28 years

7. Birth date of deceased: NOVEMBER 28 1918  
(Month) (Day) (Year)

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

Duration

8. AGE: Years 29 Months 0 Days 2 If less than one day hr. min.

Immediate cause of death acute hepatic failure

Due to Fatty Infiltration

9. Birthplace: CHILLICOTHE MISSOURI  
(City, town, or county) (State or foreign country)

Other conditions (include pregnancy within 3 months of death) 12/6

PHYSICIAN

10. Usual occupation HOUSEWIFE

Major findings: Of operations see as above

Of autopsy see as above

Underline the cause of which death should be charged statistically.

MOTHER FATHER

11. Industry or business

12. Name NOV P MAST

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

14. Maiden name UNKNOWN

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

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? (Specify type of place)

While at work? (e) Means of injury 3

16. (a) Informant MR. HOMER WANGLER

(b) Address 3313 EAST 24TH ST. TERRACE

17. (a) BURIAL (b) Date thereof DEC. 3. 1947  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation ELMWOOD CEMETERY

23. Signature Jam Walker (M. D. or other)

Address 1424 1/2 11th Date signed 12-2-47

18. (a) Signature of funeral director D. W. Newberry

(b) Address 1401 BRUSH GREEN BLDG.

19. (a) 12-3-47 (b) Thereldine Holmes  
(Date received local registrar) (Registrar's signature)

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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.....

*Bernard L. Gorman*

Licensed Embalmer No.....

*4250*

P. O. Address.....

*NC 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.