S. No. 2
M—5-43
5-17-39
I X36671

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED JAN 16 1948

THE STATE BOARD OF HEALTH OF MISSOURI

# STANDARD CERTIFICATE OF DEATH

State File No. 44205

Registration District No. 72 Primary Registration District No. 5-289 Registrar's No. 149

**1. PLACE OF DEATH:**

(a) County Clay
(b) City or town North Kansas City Winwood
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Winwwood Addition
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution XX (Specify whether
In this community 35 years
years, months or days)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Missouri (b) County Clay 24
(c) City or town Rural 0
(If outside city or town limits, write "RURAL")
(d) Street No. R.R. 487 North Kansas City 0
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No) 0
If yes, name country XX

3. (a) PRINT FULL NAME Pauline Glahn

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

4. Sex Female
5. Color or race W
6. (a) Single, widowed, married, divorced widowed
6. (b) Name of husband or wife August Glahn
6. (c) Age of husband or wife if alive XXXX years
7. Birth date of deceased March (Month) 23 (Day) 1864 (Year)

8. AGE:

| Years | Months | Days | If less than one day |
|---|---|---|---|
| 83 | 9 | 8 | XX hr. XX min. |

9. Birthplace Boonville (City, town, or county) Missouri (State or foreign country) 0
10. Usual occupation House Wife
11. Industry or business Self
FATHER
12. Name Gottlieb Liebhart
13. Birthplace XXX (City, town, or county) Germany (State or foreign country) 4
MOTHER
14. Maiden name Amelaia Waller
15. Birthplace Unknown (City, town, or county) (State or foreign country) 9
16. (a) Informant Mrs William Sieckman 1
(b) Address R.R. 487 North Kansas City Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 3 1947 (Month) (Day) (Year)
(c) Place: burial or cremation Boonville Mo.
18. (a) Signature of funeral director Morton-Smith's F.H.
(b) Address 832 Armour Rd North Kansas City
19. (a) Jan 3rd 48 (Date received local registrar) (b) Beulah Kitchen (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month Dec. day 31
year 1947 hour 4 minute 30 P. M.
21. I hereby certify that I attended the deceased from 11-15-43
death, 19..., to ..., 19...;
that I last saw h. cr alive on 12-28, 1947;
and that death occurred on the date and hour stated above.

Immediate cause of death: Uremia — Duration 6 wks
Due to Chronic form nephritis ?
Due to Hypertension & myocarditis ?
Other conditions
(Include pregnancy within 3 months of death)
Major findings:
Of operations
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?
(Specify type of place)
While at work? (e) Means of injury
23. Signature [signature] (M. D. or other) M.D.
Address 2045 Swift Date signed 1-2-48

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 8,

District File Number _____

Date Filed 1-15-48

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 Theron O. Smith

Licensed Embalmer No. 3928

P. O. Address North 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.**