

No. 2  
-1/47  
5-17-39

FILED APR 12 1948

Registration District No. 149

Primary Registration District No. 1002

48  
3  
8  
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  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 7 days  
(Specify whether 51 years years, months or days)

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. 5001 Indiana  
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No) 0  
If yes, name country.....

3. (a) PRINT FULL NAME Joseph E. Prine

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 June 29 1861  
(Month) (Day) (Year)

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

86 8 16 hr. min.

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

10. Usual occupation Pensioner

11. Industry or business.....

12. Name Joseph Prine

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

14. Maiden name Unknown

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

16. (a) Informant Record Clerk  
(b) Address K.C. General Hosp. #1

17. (a) Anatomical (b) Date thereof 3-26-48  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Western Dental College

18. (a) Signature of funeral director Weilert Funeral Home  
(b) Address Kansas City, Missouri

19. (a) 3-26-48 (b) Theraldine Holmes  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March 16 day.....  
year 1948 hour 9 minute 12 A.M.

21. I hereby certify that I attended the deceased from March 9, 1948, to March 16, 1948  
that I last saw him alive on March 16, 1948  
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral vascular hemorrhage

Due to Arteriosclerosis

Due to.....

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

Major findings:  
Of operations..... 830

Of autopsy None

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 0

23. Signature Wm W. Hart (M. D. or other) Surgeon  
Address Med. Dir. Gen'l Hosp Date signed 3-17-48

Duration

PHYSICIAN

Underline the cause of which death should be charged statistically.

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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.....

*Blaine E. Weibert*

Licensed Embalmer No. ....

*1075*

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.