

FILED JUN 12 1948  
 Registration District No. 2799

Primary Registration District No. 1002

Registrar's No. 2284

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 #1 0  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution few minutes  
(Specify whether  
 In this community about 18 years  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
 (a) State Missouri (b) County Jackson <sup>48</sup>  
 (c) City or town Kansas City  
(If outside city or town limits, write "RURAL")  
 (d) Street No. 1623 Central Street  
(If rural, give location)  
 (e) Citizen of foreign country? No (Yes or No)  
 If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Charles Howard  
 3. (b) If veteran, name war None  
 3. (c) Social Security No. Unknown

MEDICAL CERTIFICATION  
 20. DATE OF DEATH: Month May day 11  
 year 1948 hour 2:45AM minute \_\_\_\_\_ M.

4. Sex Male <sup>0</sup> 5. Color or race White  
 6. (a) Single, widowed, married, divorced Divorced  
 6. (b) Name of husband or wife Unknown 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
 7. Birth date of deceased Unknown 1890  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from 3 \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;  
 that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_;  
 and that death occurred on the date and hour stated above.

8. AGE: Years 58 Months ? Days ? If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

Immediate cause of death Gunshot Injury of head  
 Due to \_\_\_\_\_  
 Due to \_\_\_\_\_

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

Other conditions (Include pregnancy within 7 months of death)  
Deputy Coroner  
 Major findings:  
 Of operations \_\_\_\_\_  
 Of autopsy History <sup>1040</sup>

10. Usual occupation R.R. Commissary  
 11. Industry or business JOHN J GREER Co.

PHYSICIAN \_\_\_\_\_  
 Underline the cause to which death should be charged statistically.

12. Name Unknown <sup>9</sup>  
 13. Birthplace Unknown (City, town, or county) (State or foreign country)  
 14. Maiden name Unknown <sup>17</sup>  
 15. Birthplace Unknown (City, town, or county) (State or foreign country)

16. (a) Informant Investigation  
 (b) Address Coroner's office  
 17. (a) Burial (b) Date thereof 6-1-48  
(Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation Mt. Calvary: K.C. Kan.

22. If death was due to external causes, fill in the following:  
 (a) Accident, suicide, or homicide (specify) suicide  
 (b) Date of occurrence 5/11/48  
 (c) Where did injury occur? Kansas City Mo  
(City or town) (County) (State)  
 (d) Did injury occur in or about home, on farm, in industrial place, in public place?  
 While at work? No (Specify type of place) \_\_\_\_\_  
 (If Means of injury) Gunshot

18. (a) Signature of funeral director Weilert Funeral Home  
 (b) Address 2332 Monitor Place: K.C. Mo.  
 19. (a) 6-1-48 (b) Geraldine Helms  
(Date received local registrar) (Registrar's signature)

23. Signature A. E. Upsher (M. D. or P. M. D.) 1948  
 Address 2800 17men Date 5/11/48

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

MOTHER FATHER

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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. Weichert*

Licensed Embalmer No.....

*4075  
K.E. Mc*

P. O. Address.....

**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.**