

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 26655
Registrar's No. 3505

FILED SEP 4 1948

Registration District No. 149

Primary Registration District No. 1002

WRITE PLAINLY—USE 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 2 days
(Specify whether
In this community 23 Yrs.
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. 613 1/2 Main 8
(If rural, give location) 0
(e) Citizen of foreign country? P (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME

C. E. Walter

3. (b) If veteran, name war None

3. (c) Social Security No. _____

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 Unknown 1876
(Month) (Day) (Year)

8. AGE: Years 72 Months ? Days ? If less than one day _____ hr. _____ min.

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

10. Usual occupation Pensioner

11. Industry or business _____

MOTHER FATHER

12. Name Unknown 9

13. Birthplace Unknown 1
(City, town, or county) (State or foreign country)

14. Maiden name Unknown

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

16. (a) Informant Record Clerk

(b) Address R.C. General Hosp. #1

17. (a) Burial (b) Date thereof 8-27-48
(Burial, cremation or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Maple Hill, C. Cen.

18. (a) Signature of funeral director Weibert Funeral Home

(b) Address 2232 Marston Pl. Kd. Mo.

19. (a) 8-27-48 (b) Sheraldine Holmes
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. day 24
year 1948 hour 2 minute 35 P. M.

21. I hereby certify that I attended the deceased from Aug. 22, 1948 to Aug. 24, 1948; that I last saw him alive on Aug. 24, 1948; and that death occurred on the date and hour stated above.

Immediate cause of death Cerebrovascular accident

Due to _____
Due to _____

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

Major findings: Of operations _____

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? _____

While at work? _____ (Specify type of place)
(c) Means of injury _____

23. Signature W. W. [unclear] (M.D. or other) Med. Dir. Gen'l Hosp.

Address _____ Date signed 8-26-48

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

Handwritten scribbles

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. Wadsworth*
Licensed Embalmer No..... *4075*
P. O. Address..... *R.C. Me...*

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.