

FILED JUL 8 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 2792
2792

BIRTH NO. _____ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. _____

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Jackson	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kansas City		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kansas City	
c. LENGTH OF STAY (in this place) 45 yrs.		d. STREET ADDRESS (If rural, give location) 2822 Charlotte	
d. FULL NAME OF HOSPITAL OR INSTITUTION Leed's Sanitarium			

3. NAME OF DECEASED (Type or Print) a. (First) JAMES	b. (Middle) H.	c. (Last) GERMAN	4. DATE OF DEATH (Month) (Day) (Year) June 23, 1950
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5. SEX male	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH Jan. 17, 1883	9. AGE (In years last birthday) xx' 67	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lumberman	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Arkansas	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME Don't Know	13b. MOTHER'S MAIDEN NAME Don't Know	14. NAME OF HUSBAND OR WIFE Mrs. Zona German
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no	16. SOCIAL SECURITY NO. 486-05-6994	17. INFORMANT'S SIGNATURE OR NAME Mrs. Zona German, 2822 Charlotte St.	ADDRESS
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pulmonary tuberculosis far advanced.		
	II. OTHER SIGNIFICANT CONDITIONS Perniciou anemia		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from 5-15, 1950, to 6-23, 1950, that I last saw the deceased alive on 6-23, 1950, and that death occurred at _____ m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) G.K. Landis, M.D.	23b. ADDRESS Professional Bldg K.C. Mo 6-24-50	23c. DATE SIGNED
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24a. BURIAL CREMATION, REMOVAL (Specify) removal	24b. DATE 6-26-50	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State) Rogers, Arkansas.
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DATE REC'D BY LOCAL REG. 6-24-50	REGISTRAR'S SIGNATURE Sheraldine Holmes	25. FUNERAL DIRECTOR'S SIGNATURE Freeman Mortuary, Kansas City, Missouri	ADDRESS
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(Licensed Embalmer's Statement on Reverse Side)

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

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed *Willis H Bennett*

Licensed Embalmer No. *4438*

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.