

Health, Welfare
Public Service

FILED SEP 24 1957

THE DIVISION OF HEALTH AND HIGIENE
STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER
31901
Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4152

300
-57

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY Jackson	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City		c. CITY OR TOWN Kansas City	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St Marys Hosp.		d. STREET ADDRESS 3635 Tracy	
3. NAME OF DECEASED (Type or print) First Middle Last George L. Hax		4. DATE OF DEATH Month Day Year Sept. 4 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 3, 1881
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Acct. Eng.		11. BIRTHPLACE (City and state or country) Kansas City Mo.	
13a. FATHER'S NAME George L. Hax		13b. MOTHER'S MAIDEN NAME Caroline Guth	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema DUE TO (b) Acute Nephritis DUE TO (c) (K) Lobar pneumonia		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input checked="" type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) No	
20c. TIME OF INJURY Hour a.m. Month, Day, Year p.m. —		20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/>	
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) —		20f. CITY, TOWN, OR LOCATION Kansas City	
21. I attended the deceased from Sept 1-57 to Sept 4-57 and last saw her alive on Sept 4-57 Death occurred at Sept 4, 1957 by me on the date stated above; and to the best of my knowledge from the causes stated.		22a. SIGNATURE Carl D. Enns M.D.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 9/7/57	
23c. NAME OF CEMETERY OR CREMATOR Mt Moriah		23d. LOCATION (City, town, or county). Kansas City Mo	
24. FUNERAL DIRECTOR Stine & McClure		25. DATE RECD. BY LOCAL REG. 9-5-57	
26. REGISTRAR'S SIGNATURE Neva Marshall			

MEDICAL CERTIFICATION
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
All diseases in Part I must be causally related.

Dr. W. L. 9878
will be in office 1.30 to 4.30 P.M.

Box 1 - 8848



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
Signature of Student Embalmer

Signed *William M. Turner*

Licensed Embalmer No. *4648*

P. O. Address *Kansas City*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.