

MAY 15 1940

Registration District No. 399

Primary Registration District No. 1002

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: 2540 Guinotte 2
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution: Unknown (Specify whether
In this community: Unknown years, months or days)

8. (a) PRINT FULL NAME Ma. Ann Katerina Meischer
Attended by: Dr. J. H. ...

3. (b) If veteran, name war: ✓ 3. (c) Social Security No. 260

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Otto Meischer 6. (c) Age of husband or wife if alive 76 years

7. Birth date of deceased May 3 1871
(Month) (Day) (Year)

8. AGE: Years 68 Months 11 Days 3 If less than one day hr. min.

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

10. Usual occupation at home

11. Industry or business

12. Name Conrad Ruffer

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

14. Maiden name No record

15. Birthplace No record
(City, town, or county) (State or foreign country)

16. (a) Informant Ma. Edna P. Bunge

(b) Address 15 No. Prospect

17. (a) Burial (b) Date thereof 4/18/40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mount Grove

18. (a) Signature of funeral director George C. Carson

(b) Address Independence, Mo.

19. (a) April 8 1940 (b) M. D. Brown
(Date received local registrar) (Registrar's signature)

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. 2540 Guinotte
(If rural, give location)
(e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 4 - Day 6 - Year 40
year _____ hour 3 minutes _____ M.

21. I hereby certify that I attended the deceased from _____, 19____ to _____, 19____

that I last saw _____ alive on _____, 19____ and that death occurred on the date and hour stated above.

Immediate cause of death Incremental & Jugular Thrombosis

Due to _____

Due to _____

Other conditions Subarachnoid hemorrhage
(Include pregnancy within 1 month of death)

Major findings: _____
Of operations _____

Of autopsy At

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 5

23. Signature Queller (M. D. or other) _____
Address Blount Date signed _____

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

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

MOTHER FATHER

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.....

Raymond Mester

Registered Apprentice No. *28 199*

working under my personal supervision.

Signed.....

Felix Remy

Licensed Embalmer No. *H127*

P. O. Address *Independence*

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, above space should be left blank.