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FILED OCT 11 1940

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 30994  
3537  
Registrar's No. \_\_\_\_\_

Registration District No. 399

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 Mo  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:  
St Joseph Hospital  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether  
In this community 30 yrs  
years, months or days)

3. (a) PRINT FULL NAME Frank F. DeREMUS

3. (b) If veteran, name war no

3. (c) Social Security No. no

4. Sex Male

5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Emma De Remus

6. (c) Age of husband or wife if alive 55 years

7. Birth date of deceased Sept 23 1873  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>66</u>	<u>11</u>	<u>16</u>	_____ hr. _____ min.

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

10. Usual occupation Painter & Decorator

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name unknown

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

14. Maiden name Unknown

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

16. (a) Informant Diamond Kasl

(b) Address 3223 Campbell

17. (a) Burial (b) Date thereof Sept 12 1940  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Greenlawn

18. (a) Signature of funeral director Mrs C.L. Forster

(b) Address 918 Brooklyn

19. (a) Sept. 11, 1940 (b) M. M. Crowe  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson

(c) City or town Kansas City Mo.  
(If outside city or town limits, write "RURAL")

(d) Street No. 3526 Euclid  
(If rural, give location)

(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 9  
year 1940 hour 7 minute 45 P. M.

21. I hereby certify that I attended the deceased from Aug 20-1940  
\_\_\_\_\_, 19\_\_\_\_, to Sept. 9, 1940  
that I last saw him alive on Sept 19 -, 1940  
and that death occurred on the date and hour stated above.

Immediate cause of death Lobar Pneumonia Duration 21 days

Due to Cold

Due to \_\_\_\_\_

Other conditions None  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations No operations

Of autopsy Lobar Pneumonia

PHYSICIAN  
— 108  
Underline the cause to which death should be charged statistically.

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)  
(e) Means of injury \_\_\_\_\_

23. Signature Theodore Sakom (M. D. or other)

Address 4560 Main St. Date signed 9-10-40

4550 Main  
No. 8272

**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 *Denzil C. Brumby*

Licensed Embalmer No. *2726*

P. O. Address *K. P. 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.**