

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

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:
St. Joseph Hospital,
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 day
(Specify whether
In this community 48 years.
years, months or days)

3. (a) PRINT FULL NAME Mrs. Catherine Springer,

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

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed,
6. (b) Name of husband or wife Charles H. Springer, 6. (c) Age of husband or wife if alive dec. years
7. Birth date of deceased April 21, 1846.
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>94</u>	<u>5</u>	<u>5</u>	hr. _____ min. _____

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

10. Usual occupation At home,

11. Industry or business x

12. Name - Stelzer,

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

14. Maiden name Unknown,

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

16. (a) Informant Bertha Springer,
(b) Address 3642 Charlotte St., K.C., Mo.

17. (a) Burial (b) Date thereof 9-27-40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Washington Cemetery

18. (a) Signature of funeral director Stine & McClure,

(b) Address 3235 Gillham Plaza, K. C., Mo.

19. (a) 9-26-40 (b) M. M. 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. 3642 Charlotte,
(If rural, give location)
(e) If foreign born, how long in U. S. A.? 48 years, years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 26
year 1940 hour 1 minutes _____ M.

21. I hereby certify that I attended the deceased from Sept 23, 1940 to 26, 1940
that I last saw h. or alive on Sept 25, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Acute Bronchitis

Due to _____

Due to _____

Other conditions Old age infirmities
(Include pregnancy within 3 months of death)
Chronic nephritis 131

Major findings: _____

Of operations _____

Of autopsy _____

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 T. J. Beattie (M. D. or other)

Address 1202 Waldheim Bldg Date signed _____

Duration

PHYSICIAN

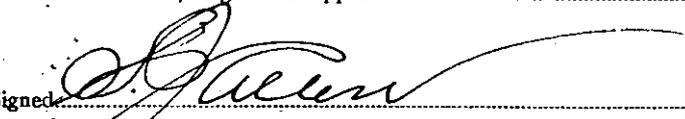
Underline the cause to which death should be charged statistically.

1971

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.....


Licensed Embalmer No. 1415

P. O. Address. H. C. M. a

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.