

No. 2
11-10-39
5-1-39
1-1-39

JAN 8 1941

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
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
210 E. Linwood
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2
(Specify whether years, months or days)
In this community 26 Years

8. (a) PRINT FULL NAME Mrs. Katherine Applegate

8. (b) If veteran, name war ----- 3. (c) Social Security No. None

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

6. (b) Name of husband or wife Unknown 6. (c) Age of husband or wife if alive -- years

7. Birth date of deceased April 2 1856
(Month) (Day) (Year)

8. AGE: Years 84 Months 8 Days 6 If less than one day hr. min.

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

10. Usual occupation At Home

11. Industry or business 6

12. Name George Gailock

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

14. Maiden name Marie Haller

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

16. (a) Informant Mrs. E. B. Schlenk

(b) Address 210 E. Linwood

17. (a) Burial (b) Date thereof 12-40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Frontenac, Kansas

18. (a) Signature of funeral director W. H. G. G. Co.

(b) Address 20 N. Linwood

19. (a) 12-9-40 (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
(If outside city or town limits, write "RURAL")
(d) Street No. 210 East Linwood
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 8th
year 1940 hour 4:20 minute P M.

21. I hereby certify that I attended the deceased from 11-28-40
_____, 19____, to 12-8-40, 19____
that I last saw him alive on 12-1, 19____
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral hemorrhage Duration 2 mo

Due to Hypertension

Due to Arteriosclerosis E. J. W.

Other conditions (Include pregnancy within 3 months of death)

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 E. Parsons (M. D. or other)
Address Plaza Med Bldg Date signed 12-8-40

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

D. N. Parsons

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..... *Harold Perry*

Licensed Embalmer No..... *4099*

P. O. Address.....

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.