

FILED OCT 13 1941

Registration District No. 399

Primary Registration District No. 1002

Registrar's No.

1. PLACE OF DEATH:

(a) County Jackson
 (b) City or town Manassas City
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: St. Lukes 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 1 week
 years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Kansas (b) County Jackson 999
 (c) City or town Overland Park 14
 (If outside city or town limits, write "RURAL")
 (d) Street No. 6184 Shawnee Ave
 (If rural, give location)
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH, Month Sept day 19
 year 1941 hour 2 minute 30 P. M.

21. I hereby certify that I attended the deceased from June 23 1941 to Sept 19 1941;
 that I last saw her alive on Sept 19, 1941;
 and that death occurred on the date and hour stated above.

Immediate cause of death _____ Duration _____
Carcinoma of gall bladder 2 yrs.

Due to _____
 Due to _____
 Other conditions _____ (Include pregnancy within 3 months of death)
46

Major findings: _____ Underline the cause to which death should be charged statistically.
 Of operations Carcinoma of gall bladder
 Of autopsy Carcinoma of gall bladder

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 _____
 23. Signature Laurence P. Engel (M. D. or other) MD
 Address Kansas City, Mo Date signed 9-20-41

3. (a) PRINT FULL NAME Julia Sophia Freyler
 3. (b) If veteran, name war MO
 3. (c) Social Security No. MO

4. Sex Female 5. Color or race Wh. 6. (a) Single, widowed, married, divorced Divorced
 6. (b) Name of husband or wife Untersohn 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased May 19 1865
 (Month) (Day) (Year)

8. AGE: Years 76 Months 4 Days 0 If less than one day _____ hr. _____ min.

9. Birthplace Washington D. C.
 (City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business _____

12. Name August Westerfield
 13. Birthplace Germany
 (City, town, or county) (State or foreign country)
 14. Maiden name Emma Paole
 15. Birthplace Virginia
 (City, town, or county) (State or foreign country)

16. (a) Informant Mrs Sarah V Smith

(b) Address 7839 Mission Rd Mission Mo

17. (a) Removal (b) Date thereof 9-19-1941
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Overland Park Kans

18. (a) Signature of funeral director St. Agnes Funeral Home

(b) Address Overland Park Kans
 19. (a) 9/21/41 (b) M. M. Crowe
 (Date received local registrar) (Registrar's signature)

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

83315

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 J. Royce Hoop
Licensed Embalmer No. 3579
P. O. Address Cleveland Park 14

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.