

No. 2
1-4-41
17-39
X26390

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **30862**
3620
Registrar's No.

Registration District No. **399**
Primary Registration District No. **100**

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: **2709 Charlotte**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **48 Years**
(Specify whether years, months or days)

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. **2709 Charlotte**
(If rural, give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME **MRS. MAGDELINE KUNZ**
3. (b) If veteran, name war **No**
3. (c) Social Security No. **None**

4. Sex **Female** 5. Color or race **White**
6. (a) Single, widowed, married, divorced **Married**
6. (b) Name of husband or wife **Jacob Kunz**
6. (c) Age of husband or wife if alive **77** years
7. Birth date of deceased **February 8 1870**
(Month) (Day) (Year)

8. AGE: Years **71** Months **7** Days **20**
If less than one day hr. min.

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

10. Usual occupation **At Home**

11. Industry or business

MOTHER FATHER { 12. Name **Joseph Kissner**

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

14. Maiden name **No Record**

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

16. (a) Informant **Jacob Kunz**

(b) Address **2709 Charlotte**

17. (a) **Burial** (b) Date thereof **9-30-41**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Calvary**

18. (a) Signature of funeral director **John W. Wagner**
Kansas City, Missouri

(b) Address **9/29/41**
19. (a) (Date received local registrar) (b) **M. M. Crow**
(Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Sept.** day **28th**
year **1941** hour **11** minute **15** A.M.

21. I hereby certify that I attended the deceased from **Nov 17**
1940 to **Sept 28** 19**41**
that I last saw **her** alive on **Sept 22** 19**41**
and that death occurred on the date and hour stated above.

Immediate cause of death **Atherosclerosis, Diabetes, Hypertension, pyelitis cystica**
Due to **870**

Due to **870**

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations **870**

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

22. Signature **James H. O'Neil** (M.D. or other) Date signed **9/29/41**
Address **1200 Professional**

Duration **17 yrs**
PHYSICIAN
Underline the cause to which death should be charged statistically.

1:30 P.M. - T.O.
Prof. Bell
263422

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 *A. B. Hauschild*

Licensed Embalmer No. *4159*

P. O. Address. *K E W*

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.