

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

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

State File No. **40857**
4534
Registrar's No. _____

Registration District No. **24** **102399**

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:
804 East 42nd. St.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **55 Yrs.** / (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County **Jackson** **041**
(c) City or town **Kansas City** **39**
(If outside city or town limits, write "RURAL")
(d) Street No. **804 East 42ns. St.**
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **Mrs. Katherine T. Bessenbacher**
3. (b) If veteran, name war **No**
3. (c) Social Security No. **None**

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **December** Day **6th**
year **1941** hour **2 P.M.** minute _____ M.

4. Sex **Female** 5. Color or race **White**
6. (a) Single, widowed, married, divorced **Widow**
6. (b) Name of husband or wife **Charles A. Bessenbacher**
6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased **March 15, 1867**
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from _____, 19____ to _____, 19____;
that I last saw him _____ alive on _____, 19____
and that death occurred on the date and hour stated above.

8. AGE: Years **74** Months **8** Days **21** If less than one day _____ hr. _____ min.

Immediate cause of death **Coronary occlusion**
Due to **Arteriosclerosis** **10 years**
Due to **Hypertension** **10 years**
Other conditions (Include pregnancy within 3 months of death) **gfa**

9. Birthplace **Hannibal, Mo.**
(City, town, or county) (State or foreign country)
10. Usual occupation **At Home**

Major findings: Of operations **None**
Of autopsy **No**
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

MOTHER FATHER { 11. Industry or business _____
12. Name **James Brady**
13. Birthplace **Ireland**
(City, town, or county) (State or foreign country)
14. Maiden name **Bridget O'Dally**
15. Birthplace **Ireland**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. John P. Becker**
(b) Address **804 East 42ns. St.**
17. (a) **Burial** (b) Date thereof **Dec. 9, 1941**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **St. Marys**

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? **No**

18. (a) Signature of funeral director **Thomas E. Quirk Funeral Home**
(b) Address **4316 Inwood Ave**
19. (a) **Dec 8, 1941** (b) **M. M. Crowe**
(Date received local registrar) (Registrar's signature)

23. Signature **Mrs. Caswell** (Date signed) **12-8-41**
Address **224 Westport Ave**

STATE OF MISSOURI

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 *Thomas E. Jurik*

Licensed Embalmer No. *3775*

P. O. Address *R. C. 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.

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BUREAU OF THE CENSUS

State File No.

Registration District No.

Primary Registration District No.

Registrar's No. **4534**

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

1. PLACE OF DEATH:

(a) County.....
(b) City or town.....
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution.....
804 16 42nd Dr
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution..... (Specify whether)
In this community..... (Specify whether)
years, months or days

3. (a) PRINT FULL NAME **Katherine Bessenbacher**

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

4. Sex **FE** 5. Color or race..... 6. (a) Single, widowed, married, divorced.....

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

7. Birth date of deceased..... (Month) (Day) (Year)

8. AGE: **74** Years Months Days If less than one day..... hr..... min.

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

10. Usual occupation.....

11. Industry or business.....

MOTHER FATHER { 12. Name.....

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

14. Maiden name.....

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

16. (a) Informant.....

(b) Address.....

17. (a)..... (b) Date thereof..... (Month) (Day) (Year)

(c) Place: burial or cremation.....

18. (a) Signature of funeral director.....

(b) Address.....

19. (a) **1-25742** (Date received local registrar) (b) **M. M. Brown** (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State..... (b) County.....
(c) City or town..... (If outside city or town limits write "RURAL")
(d) Street No..... (If rural, give location)
(e) If foreign born, how long in U. S. A.?..... years.

20. DATE OF DEATH: Month **Dec** day **6** year **1941** hour..... minute..... M.

21. I hereby certify that I attended the deceased from..... 19..... to..... 19..... that I last saw him..... alive on..... and that death occurred on the date and hour stated above.

Immature cause of death..... **Coronary Occlusion**

Due to.....

Due to.....

Other conditions..... (Include pregnancy within 3 months of death) **94a**

Major findings: Of operation.....

Of autopsy..... **94a**

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 **M. M. Brown** (M. D. or other)

Address **715 Orange Alley St. P. Mo. 1-25-42**

MEDICAL CERTIFICATION

SUPPLEMENTARY
94a
94a
94a

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

S-40857