

Registration District No. 1126 NOV 9 1942

Primary Registration District No. 1002

Registrar's No. 3855

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: K.C. General Hospital 0.1
(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 lifetimes
years, months or days)

3. (a) PRINT FULL NAME William F. Shubert

3. (b) If veteran, name war no 3. (c) Social Security No. 96-01-4434

4. Sex male 5. Color or Race W 6. (a) Single, widowed, married, divorced 2 wid
6. (b) Name of husband or wife unk 6. (c) Age of husband or wife if alive 1907 years
7. Birth date of deceased May 9 (Month) (Day) (Year)

8. AGE: Years 45 Months 5 Days 4 If less than one day hr. min.

9. Birthplace Pa 1 (City, town, or county) (State or foreign country)

10. Usual occupation Chamber

11. Industry or business

12. Name Bernard Shubert
13. Birthplace no record 9 (City, town, or county) (State or foreign country)
14. Maiden name no record
15. Birthplace no record 9 (City, town, or county) (State or foreign country)

16. (a) Informant Lottie Pickett

(b) Address 411 N. Montcal

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-19-42 (Month) (Day) (Year)

(c) Place: burial or cremation Green Lawn

18. (a) Signature of funeral director M. C. Foster

(b) Address 918 Brooklyn

19. (a) 10-19-42 (Date received local registrar) (b) M. M. Crowe (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. 4805 East 59th Street
(If rural, give location)
(e) Citizen of foreign country? (Yes or No) 0
If yes, name country.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 15th
year 1942 hour 9 minute 30 A.M. M.

21. I hereby certify that I attended the deceased from 10-14-42 19... to 10-15-42 19...
that I last saw him alive on 10-15-42 19...
and that death occurred on the date and hour stated above.

Immediate cause of death Cardiac Asthma
Due to gsc
Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations
Of autopsy None

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) Means of injury
23. Signature Druey R. Thon (M. D. or other)
Med. Dir. K.C. General Hospital
Address Date signed

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

48
206

48
206

0

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

Wm. C. Browning

Licensed Embalmer No. *2724*

P. O. Address: *J. C. No*

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.