

Registration District No. 149

Primary Registration District No. 1002

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: Trinity Lutheran Hosp  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 7 days (Specify whether years, months or days)  
In this community Born

3. (a) PRINT FULL NAME: OLLIE F. DAUB

3. (b) If veteran, name war: no 3. (c) Social Security No. none

4. Sex Fe 5. Color or race W 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Jacob F. Daub 6. (c) Age of husband or wife if alive 44 years

7. Birth date of deceased: Apr 23 1896  
(Month) (Day) (Year)

8. AGE: Years 46 Months 8 Days 16 If less than one day hr. min.

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

10. Usual occupation Cheer + Coomer Restaurant

11. Industry or business Queen of Hearts Cafe

12. Name Frank Clayton

13. Birthplace dent know

14. Maiden name Lebbie Neighbors

15. Birthplace dent know

16. (a) Informant Mrs Carl Conn

(b) Address 1322 Specker

17. (a) Funeral (b) Date thereof Jan 13 - 43  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Highland Park H.C.H.S

18. (a) Signature of funeral director Bob F. Porter + Sons

(b) Address 915 210 N. 15th St

19. (a) 1-11-43 (b) M. M. Crowe  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Kansas (b) County Wyandotte  
(c) City or town Kansas City  
(If outside city or town limits, write "RURAL")  
(d) Street No. 1008 Minnesota Ave  
(If rural, give location) 2  
(e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 9  
year 1943 hour 6 minute 9 P. M.

21. I hereby certify that I attended the deceased from Jan 2 1943 to Jan 9 1943

that I last saw her alive on Jan 9 1943 and that death occurred on the date and hour stated above.

Immediate cause of death Arterio Sclerosis Duration 5 days

Due to Coronary Sclerosis 5 days

Due to Arterio Sclerosis

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy no

PHYSICIAN

Underline the cause to which death should be charged statistically.

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) (c) Means of injury \_\_\_\_\_

23. Signature Carl Conn (M. D. or other)

Address 1108 E 6th Date signed 1-11-43

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

MOTHER FATHER

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**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.....

Licensed Embalmer No.....

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, fact should be so stated above.**