

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:
St. Mary's Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **13 Hours**
(Specify whether years, months or days)

In this community **14 Years**

3. (a) PRINT FULL NAME **Charles A. Sartain**

3. (b) If veteran, name war **no**

3. (c) Social Security No. **none**

4. Sex **Male**

5. Color or race **White**

6. (a) Single, widowed, married, divorced **Married**

6. (b) Name of husband or wife **Blanche C. Sartain**

6. (c) Age of husband or wife if alive **60** years

7. Birth date of deceased **Jan. 3, 1881**
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
62	6	3	hr. min.

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

10. Usual occupation **Retired**

11. Industry or business **Auto Wheel & Rim**

MOTHER FATHER

12. Name **William Sartain**

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

14. Maiden name **Georgianne Rogers**

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

16. (a) Informant **Mrs. Blanche C. Sartain**

(b) Address **Newbern Hotel**

17. (a) **Cremation** (b) Date thereof **7-8-43**
(Burial, cremation, or removal) (Month) (Day) (Year)

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

18. (a) Signature of funeral director **Freeman Mortuary**

(b) Address **Kansas City, Missouri**

19. (a) **7-8-43** (b) **Def. T. C. Brown**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED: **48**

(a) State **Missouri** (b) County **Jackson** **3**

(c) City or town **Kansas City** **8**
(If outside city or town limits, write "RURAL")

(d) Street No. **Newbern Hotel 525 E. Arman**
(If rural, give location)

(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **July** day **6**
year **1943** hour **10** minute **P.** M.

21. I hereby certify that I attended the deceased from **6/20**, 19**42** to **7/20**, 19**43**
that I last saw him alive on **7/6**, 19**43**.
and that death occurred on the date and hour stated above.

Immediate cause of death **Coronary Thrombosis**
Recurrent

Duration **1 da**

Due to **Myocarditis Chronic 2yr.**

Due to _____

Other conditions **93d**
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____

Of autopsy _____

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) **no**

(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 **James R. Bledy** (M. D. or other)
814 Center Bldg Date signed **7/7/43**

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

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.