

27483

State File No.

3519

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUSSTATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHRegistration District No. 149Primary Registration District No. 1002

Registrar's No.

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:
6430 Wornall Road
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution XX (Specify whether
 In this community Life years, months or days)

3. (a) PRINT FULL NAME Mrs. Emma Sutorius

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

4. Sex Fe 5. Color or race Wh 6. (a) Single, widowed, married, divorced Widowed
 6. (b) Name of husband or wife Adolph Sutorius 6. (c) Age of husband or wife if alive XX years
 7. Birth date of deceased March 12 1857
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
86 5 2 hr. min.

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

10. Usual occupation At Home

11. Industry or business

12. Name Bernard Knapp13. Birthplace Germany
(City, town, or county) (State or foreign country)14. Maiden name No Record15. Birthplace Germany
(City, town, or county) (State or foreign country)16. (a) Informant Paul B. Sutorius(b) Address 1120 West 38th St.17. (a) Cremation (b) Date thereof 8-16-43
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation Elmwood Cemetery18. (a) Signature of funeral director J. Wagner(b) Address Kansas City, Mo.19. (a) 8-14-43 (b) D. E. Brown
(Date received local registrar) (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. 6430 Wornall Road
(If rural, give location)
 (e) Citizen of foreign country? No (Yes or No)
 If yes, name country 1

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 14th
 year 1943 hour 12: minute 10 P. M.

21. I hereby certify that I attended the deceased from July 1 -
1943 to Aug 14, 1943,
 that I last saw h. alive on Aug 13, 1943
 and that death occurred on the date and hour stated above.

Immediate cause of death

Due to uremiaDue to arteriosclerosis

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

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 _____

23. Signature D. E. Brown (M. D. or other)
 Address 924 Oregon St. Mo. Date signed 8-15-43

(Licensed Embalmer's Statement on Reverse Side)

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

MOTHER FATHER

PHYSICIAN

Underline the cause to which death should be charged statistically.

934
Angeles

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. R. Haunschuld
Licensed Embalmer No. 4459
P. O. Address D. 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.

Registration District No. 149

Primary Registration District No. 1002

1. PLACE OF DEATH:
(a) County Jackson
(b) City or town J.C.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community Life years, months or days

3. (a) PRINT FULL NAME Emma Lutorius
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced W
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Mar 12 1885 (Month) (Day) (Year)

8. AGE: Years 86 Months 5 Days _____ (Less than one day) 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)
(Burial, cremation, or removal) (Place: burial or cremation)

18. (a) Signature of funeral director _____ (b) Address _____

19. (a) _____ (b) _____ (Date received local registrar) (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) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Aug day 14 year 1945 hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____ 19____; that I last saw him/her alive on _____ 19____; and that death occurred on the date and hour stated above.
Immediate cause of death _____

Due to anemia on basis of chronic arteriosclerosis
Due to arteriosclerosis
Other conditions: _____ (Include pregnancy within 3 months of death)

Major findings: _____
Of operations _____
Of autopsy _____
131a

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 W. E. Knapp (M. D. or other) _____
Address _____ Date signed _____

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

SUPPLEMENTARY

PHYSICIAN
Underline the cause to which death should be charged statistically.

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