

FILED DEC 3 1943
199

State File No. _____
Registrar's No. 4778

Registration District No. _____

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 Lansas City
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
K. C. General Hospital No. 10
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 3 days
(Specify whether in this community _____ years, months or days) unknown

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson

(c) City or town Lansas City
(If outside city or town limits, write "RURAL")

(d) Street No. 4106 E. 40 Terr.
(If rural, give location)

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

3. (a) PRINT FULL NAME John E. Payrleithner

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, widowed

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

7. Birth date of deceased November 11 1867
(Month) (Day) (Year)

8. AGE: Years 75 Months 11 Days 26 If less than one day 29 hr. _____ min.

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

10. Usual occupation none

11. Industry or business _____

MOTHER - FATHER

12. Name Charles Payrleithner

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

14. Maiden name Rose Burton

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

16. (a) Informant Record Clerk

(b) Address General Hospital No. 1

17. (a) burial (Burial, cremation, or removal) (b) Date thereof 11-12-43
(Month) (Day) (Year)

(c) Place: burial or cremation buried

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

(b) Address City

19. (a) 11-12-43 (Date received local registrar) (b) D. E. Brown (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November day 10th year 1943 hour 1 minute 15 A.M.

21. I hereby certify that I attended the deceased from November 7th 1943 to November 10th 1943 that I last saw him alive on November 10th 1943 and that death occurred on the date and hour stated above.

Immediate cause of death Acute pulmonary infarction Duration _____

Due to _____

Due to 11/10

Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations _____

Of autopsy See above

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) (e) Means of injury _____

23. Signature [Signature] (M. D. or other) _____
Address Med. Dir. Gen'l Hosp. Date signed 11-10-43

1961 E I 900

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.