

Registration District No. 149

Primary Registration District No. 1802

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:
4622 Mill Creek
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution.....
In this community 15 years
years, months or days) (Specify whether

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. 4622 Millcreek Blvd.
(If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country. 0

3. (a) PRINT FULL NAME Mrs. Augusta Shewmaker
(b) If veteran, name war. No
(c) Social Security No. None

4. Sex Female 5. Color or race White
6. (a) Single, widowed, married, divorced, Widow
6. (b) Name of husband or wife W. H. Shewmaker
6. (c) Age of husband or wife if alive. _____ years
7. Birth date of deceased. June 8 1864
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
79 6 15 _____ hr. _____ min.

9. Birthplace Lancaster, Co. Ohio
(City, town, or county) (State or foreign country)

10. Usual occupation At Home

11. Industry or business.....
12. Name Helmeth Pasal
13. Birthplace Germany
(City, town, or county) (State or foreign country)
14. Maiden name Sophia Doss
15. Birthplace Germany
(City, town, or county) (State or foreign country)

16. (a) Informant Miss Audra Shewmaker
(b) Address 1304 East 32nd Terr.
17. (a) Burial (b) Date thereof 12/28/43
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Savannah, Mo.

18. (a) Signature of funeral director Freeman Mortuary
(b) Address Kansas City, Missouri
19. (a) 12-27-43 (b) N. E. Brown
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 12 day 23
year 43 hour 8 minute 20 P. M.
21. I hereby certify that I attended the deceased from July
1943 to 12/23 1943
that I last saw her alive on 12/10 1943
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Thrombosis
Due to Chronic Hypertension
Cerebral Arteriosclerosis
Due to Arteriosclerosis Generalized
Other conditions (Include pregnancy within 3 months of death) 13hr

Major findings:
Of operations.....
Of autopsy.....

Duration 1 day
10 yrs +
10 yrs
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 James V. Brown (M. D. or other)
Address Playa Med Bldg. No. 12/23/43 Date signed

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

MOTHER FATHER

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 Elmer C. Wedelin
Licensed Embalmer No. 3495-
P. O. Address Waukegan City, Ill.

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.