

FILED FEB 10 1944

State File No. _____

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 304

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:
4820 East 18th, St. Terr.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community 40 years
years, months or days)

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. 4820 East 18th, St. Terr.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Louis H. Metzler

3. (b) If veteran, name war No 3. (c) Social Security No. None

4. Sex Male 5. Color or race Wh. 6. (a) Single, widowed, married, divorced Single

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

7. Birth date of deceased April 15th, 1872
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
71 4 3 _____ hr. _____ min.

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

10. Usual occupation Old Age Pensioner

11. Industry or business _____

12. Name Louis Metzler

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

14. Maiden name Kathryn Heice

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

16. (a) Informant Alphaus Metzler

(b) Address 4820 East 18th Terr.

17. (a) Burial (b) Date thereof 1/20/44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. St Marys Cem

18. (a) Signature of funeral director Earp Funeral Home

(b) Address Kansas City Missouri

19. (a) Jan 19, 1944 (b) J. E. Brown
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 18th
year 1944 hour 5 minute A. M.

21. I hereby certify that I attended the deceased from Nov 24, 1943, to Jan 18, 1944

that I last saw h. _____ alive on _____, 19____
and that death occurred on the date and hour stated above.

Immediate cause of death Broncho-pneumonia Duration 3 days

Due to Anterior Scleritis
Chronic Myocarditis

Due to Ward of City Hospital 2 months

Other conditions _____
(Include pregnancy within 3 months of death)
W.R. Foster M.D.

Major findings:
Of operations _____

Of autopsy 93h

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 W.R. Foster M.D. (M. D. or other) _____
Date signed 1-29-44

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

MOTHER FATHER

*Dr. Hersten
1579 Linden*

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.....

John B. Camp

Licensed Embalmer No.....

2955

P. O. Address.....

H.C. 9th

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.