

FILED APR 15 1944/9
Registration District No. 1002

Primary Registration District No. 1002

Registrar's No. 1574

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

1. PLACE OF DEATH: Jackson

(a) County Kansas City

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

(c) Name of hospital or institution: General Hospital # 1
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 8 days
In this community 16 years (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson

(c) City or town Kansas City
1332 E. 35th St.
(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 _____

3. (a) PRINT FULL NAME Marion Biringer

3. (b) If veteran, name war no

3. (c) Social Security No. none

4. Sex M 5. Color or race W

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

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

7. Birth date of deceased Jan. 1, 1876
(Month) (Day) (Year)

8. AGE: Years 73 Months 3 Days 7
If less than one day _____ hr. _____ min.

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

10. Usual occupation RETIRED

11. Industry or business _____

MOTHER, FATHER { 12. Name UNKNOWN

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

14. Maiden name UNKNOWN

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

16. (a) Informant HOSPITAL RECORDS

(b) Address GENERAL HOSPITAL #1

17. (a) REMOVAL (b) Date thereof 4/8/44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation LEAVENWORTH, KANS

18. (a) Signature of funeral director J.C. DAVIS UND. CO.

(b) Address LEAVENWORTH, KANS

19. (a) 4-9-44 (b) D. E. Brown
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 8
year 1944 hour 8 minute 40 A. M.

21. I hereby certify that I attended the deceased from Mar 30 to April 8 1944
and that death occurred on the date and hour stated above.
Immediately last saw him alive on April 8 1944

Immediate cause of death Acute Coronary Occlusion

Due to _____

Due to _____

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

Major findings: 94a

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)

Means of injury _____

23. Signature D. E. Upsher (M. D. or other) M.D.

Address 23 McCoy Date signed _____

Duration _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

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.