

FILED DEC 9 1944

Registration District No. _____

Primary Registration District No. 1002

Registrar's No. _____

1. PLACE OF DEATH: Jackson, (a) County
 (b) City or town: Kansas City
 (c) Name of hospital or institution: St. Mary's Hospital, 1
 (d) Length of stay: In hospital or institution 1 day
 In this community 2 years (Specify whether years, months or days) *Delberta*

2. USUAL RESIDENCE OF DECEASED:
 (a) State: Nebraska (b) County: _____
 (c) City or town: Falls City
 (d) Street No. _____
 (e) Citizen of foreign country? X (Yes or No)
 If yes, name country: X

3. (a) PRINT FULL NAME Miss Louise Wastell

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month 11 day 28
 year 44 hour 10:10 minute P.M.

3. (b) If veteran, name war: no. 3. (c) Social Security No. 491-20-3470
 4. Sex: Female 5. Color or race: White 6. (a) Single, widowed, married, divorced: Single
 6. (b) Name of husband or wife: X 6. (c) Age of husband or wife if alive: X years
 7. Birth date of deceased: June 20 1928 (Month) (Day) (Year)

21. I hereby certify that I attended the deceased from 11/28/44, 19, to 11/28/44, 19;
 that I last saw him alive on 11/28/44, 19;
 and that death occurred on the date and hour stated above.

8. AGE:	Years	Months	Days	If less than one day
	16	5	8	hr. min.

Immediate cause of death: *Diabetic Coma*
 Due to: *Diabetic Mellitus*

9. Birthplace: Kansas (City, town, or county) (State or foreign country)
 10. Usual occupation: X
 11. Industry or business: X

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

MOTHER FATHER
 12. Name: Walter Wastell
 13. Birthplace: Illinois (City, town, or county) (State or foreign country)
 14. Maiden name: *Olivera Murphy* Ohio
 15. Birthplace: Ohio (City, town, or county) (State or foreign country)

Major findings:
 Of operations: _____
 Of autopsy: *Suction*
 Underline the cause to which death should be charged statistically.

16. (a) Informant: Walter Wastell, (b) Address: Falls City, Nebraska, removal (b) Date thereof: 11-29-44
 (Burial, cremation, or removal) (Month) (Day) (Year)

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? _____

(c) Place: burial or cremation: Falls City, Nebraska, Stine & McClure,
 18. (a) Signature of funeral director: _____ (b) Address: 3235 Gillham Plaza, Kansas City, Mo.
 19. (a) 11-29-44 (b) *D. E. Brown*
 (Date received local registrar) (Registrar's signature)

(Specify type of place) (e) Means of injury _____
 While at work? _____
 23. Signature: *Opsetch* _____
 Address: *Kenn* _____ Date signed: *11/29/44*

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

JUL 20 1948

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 Robert H Reed

Licensed Embalmer No. 3745

P. O. Address Kansas City 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.