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FILED FEB 6 1945

State File No. _____

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 438

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Kansas City

(c) Name of hospital or institution: 6316 Walnut
(If outside city or town limits, write "RURAL" and name of township)

(d) Length of stay: In hospital or institution XX
29 years (Specify whether years, months or days)

In this community _____

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. 6316 Walnut
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country _____

3. (a) PRINT FULL NAME MRS. THECKLA SPRINGER

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

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

6. (b) Name of husband or wife Herman Springer 6. (c) Age of husband or wife if alive 74 years

7. Birth date of deceased December 26 1872
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>72</u>	<u>0</u>	<u>29</u>	hr. _____ min.

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

10. Usual occupation Housewife

11. Industry or business _____

12. Name August Kruse

13. Birthplace Germany
(State or foreign country)

14. Maiden name No record

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

16. (a) Informant Herman Springer

(b) Address 6316 Walnut

17. (a) Burial (b) Date thereof 1-27-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Union Cemetery

18. (a) Signature of funeral director J.W. Wagner

(b) Address Kansas City, Mo.

19. (a) 1-27-45 (b) D.E. Brown
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 25
year 1945 hour 9:00 minute A. M.

21. I hereby certify that I attended the deceased from Jan 25, 1945 to Jan 25, 1945
that I last saw her alive on Jan 25, 1945
and that death occurred on the date and hour stated above.

Immediate cause of death of carcinoma Duration 2 yrs.

Due to _____

Due to 462

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

Major findings: Perforated carcinoma of cecum with abscess
Of operations of cecum with abscess
of cecum with abscess
of cecum with abscess

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 0

23. Signature James H. O'Neil (M. D. or other)

Address 510 Professional Bldg. Date signed 1/27/45

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

174 0580
Magowan 24 4559

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 *Alvin R. Haunschild*

Licensed Embalmer No. *4159*

P. O. Address *Kansas City*

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.