

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: 1809 Myrtle
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 6 mos.
(Specify whether years, months or days)
 In this community 40 years
(Specify whether 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. 1809 Myrtle
(If rural, give location)
 (e) Citizen of foreign country? No (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME MRS. MARGARET ST. JOHN

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** Widowed

6. (b) Name of husband or wife Wm. St. John **6. (c) Age of husband or wife if alive** XX years

7. Birth date of deceased April 9 1854
(Month) (Day) (Year)

8. AGE: Years 90 Months 9 Days 6
If less than one day hr. _____ min.

9. Birthplace Mt. Vernon Ill.
(City, town, or county) (State or foreign country)

10. Usual occupation At Home

11. Industry or business _____

12. Name George Treese

13. Birthplace No Record Ia
(City, town, or county) (State or foreign country)

14. Maiden name Sarah Mahaffey

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

16. (a) Informant Marjorie St. John

(b) Address 3644 Summit

17. (a) Burial Edgewood **(b) Date thereof** Jan 17 1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Edgewood

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

(b) Address Kansas City, Mo.

19. (a) 1-16-45 **(b) P. E. Brown**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 15th
 year 1945 hour 4:00 minute _____ P. M.

21. I hereby certify that I attended the deceased from now
 _____, 1944, to Jan 15, 1945
 and that death occurred on the date and hour stated above.

Immediate cause of death myocardial failure
arteriosclerosis
old age
 Due to _____
 Due to _____

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

Major findings: _____
 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?

23. Signature J. P. [unclear] **(M. D. or other)** _____
(Specify type of place) (e) Means of injury
 Address 7 [unclear] Rd. Date signed 1/16/40

Duration _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

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

11 - 3434
Alvin R. Hauschke

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. Hauschke

Licensed Embalmer No. 4159

P. O. Address Texas 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.