

FILED FEB 17 1945
Registration District No. _____

Primary Registration District No. 1002

Registrar's No. 583

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

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:
K. C. General Hospital No. 10
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution. 7 days
(Specify whether In this community _____ years, months or days) unknown

3. (a) PRINT FULL NAME William Slusher

3. (b) If veteran, name war no

3. (c) Social Security No. none

4. Sex Male 5. Color or race White

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 Dec. 17, 1862
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>82</u>	<u>1</u>	<u>15</u>	hr. _____ min. _____

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

10. Usual occupation Unknown

11. Industry or business Unknown

MOTHER FATHER { 12. Name Tom Slusher

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

14. Maiden name Liza Jenkins

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

16. (a) Informant Record Clerk

(b) Address K. C. General Hospital No.

17. (a) Removal (b) Date thereof 2-5-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Lawrence Kansas

18. (a) Signature of funeral director Geo M. Callier

(b) Address 200 Independence St

19. (a) 2-5-45 (b) T. E. Brown (1/2)
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 48

(c) City or town Kansas City
(If outside city or town limits, write "RURAL")

(d) Street No. 514 Main
(If rural, give location)

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

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month February day 2
year 1945 hour 9 minute 55 P. M.

21. I hereby certify that I attended the deceased from January 26, 1945 to February 2, 1945
that I last saw him alive on February 2, 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma of prostate

Due to _____

Due to _____

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

Major findings:
Of operations _____

Of autopsy None

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) Years of injury

23. Signature Clark W. Sealy M.D.
Address Med. Dir. Gen'l Hosp Date signed 2-3-45

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 Geo M. Callier

Licensed Embalmer No. 3839

P. O. Address. Indep. 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.