

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 1284

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:  
Trinity Lutheran Hospital,  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 4 days  
(Specify whether years, months or days)

In this community as above

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Lafayette

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

(d) Street No. \_\_\_\_\_  
(If rural, give location)

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

If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Henry Offel

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 W

6. (b) Name of husband or wife Henrietta

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

7. Birth date of deceased: 6 - 6 - 1858  
(Month) (Day) (Year)

8. AGE: Years 86 Months 9 Days 13  
If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

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

10. Usual occupation at home,

11. Industry or business farmer,

12. Name Christopher Offel

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

14. Maiden name Margaret Schaffner

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

16. (a) Informant Mrs. Fritz Kempel

(b) Address Higginsville Mo.

17. (a) removal (b) Date thereof 3-20-45  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Lexington, Mo.

18. (a) Signature of funeral director Stine & McClure,

(b) Address 3235 Gillham Plaza, K. C., Mo.

19. (a) 3-20-45 (b) H. E. Brown  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 3-19-45 day \_\_\_\_\_  
year \_\_\_\_\_ hour 9 minute 45 P. M.

21. I hereby certify that I attended the deceased from 3-15-45 to 3-18-45  
and that death occurred on the date and hour stated above.

Immediate cause of death Suppression of urine  
Ataxia

Due to Acute Nephritis - Chronic

Due to arterio-sclerosis

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings: 131 b  
Of operations \_\_\_\_\_

Of autopsy no.

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 \_\_\_\_\_

23. Signature Geo. B. Korbay (M. D. certified)  
Address 1324 Poplar and Date signed 3-20-45

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

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**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.**