

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 12200
Registrar's No. 1578

FILED APR 23 1945

Registration District No. 149

Primary Registration District No. 1002

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. 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 mo. 16 days
(Specify whether years, months or days) 43 yrs

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. 1508 1/2 Myrtle
(If rural, give location) No
(e) Citizen of foreign country? No (Yes or No)
If yes, name country.

3. (a) PRINT FULL NAME Richard Mix

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

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

6. (b) Name of husband or wife Anna Mix 6. (c) Age of husband or wife if alive 71 years

7. Birth date of deceased April 18 1869
(Month) (Day) (Year)

8. AGE: Years 75 Months 11 Days 18 If less than one day hr. min.

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

10. Usual occupation Farmer - retired

11. Industry or business

12. Name Frank Mix

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

14. Maiden name Rosalie Borowsky

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

16. (a) Informant Mrs. W. C. Hilker

(b) Address 3024 Brighton K.C. Mo

17. (a) Burial (b) Date thereof 4-9-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Floral Hills

18. (a) Signature of funeral director Earp Furnal Home

(b) Address 4139 E 15th, K.C. Mo

19. (a) 4-7-45 (b) Sheraldine Holmes
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 6
year 1945 hour 9 minute 25 P.M.

21. I hereby certify that I attended the deceased from February 18, 1945 to April 6, 1945
that I last saw him alive on April 6, 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Bronchopneumonia Duration

Due to

Due to

Other conditions (Include pregnancy within 3 months of death) 107

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) Means of injury

Signature Clark A. Tolpelt (M.D. or other)

Address Med. Dir. Gen'l Hosp. Date signed 4-7-45

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

8
3
8

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.....

John B. Camp
.....
Licensed Embalmer No. *2955*
.....
P. O. Address *H.C. 9th*
.....

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.