

U.S. No. 2
FORM-5-43
Rev. 5-17-39
I X36671

FILED APR 23 1945
Registration District No. **119**

Primary Registration District No. **1002**

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

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Kaw
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
5331 Highland Sittle Sisters of the Poor
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 3 years--8 months
(Specify whether years, months or days)

In this community 3 years-8 months
(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. 5331 Highland
(If rural, give location)

(e) Citizen of foreign country? 0 (Yes or No)

If yes, name country _____

3. (a) PRINT FULL NAME MRS JULIA WILLENBURG

3. (b) If veteran, name war No

3. (c) Social Security No. None

4. Sex Female

5. Color or race White

6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife unknown

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

7. Birth date of deceased March 2 1865
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>80</u>	<u>1</u>	<u>11</u>	hr. _____ min. _____

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

10. Usual occupation None

11. Industry or business _____

MOTHER FATHER {

12. Name Joseph Diehl

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

14. Maiden name Mary Feigenbritz

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

16. (a) Informant Living Sisters of the Poor

(b) Address 5331 Highland

17. (a) Removal (Burial, cremation, or removal)

(b) Date thereof 4/14/45
(Month) (Day) (Year)

(c) Place: burial or cremation Humboldt, Kansas

18. (a) Signature of funeral director Dwight W. Robin Co.

(b) Address 20 West Linwood

19. (a) 4-14-45 (Date received local registrar)

(b) Geraldine Holmes (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 13th day April
year 1945 hour 12:00 minute P M.

21. I hereby certify that I attended the deceased from April 1 1945 to April 12 1945
that I last saw her alive on April 12 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Coronary thrombosis Duration 1 Day

Due to Myocarditis 5 year

Due to Arterio-sclerosis 15 year

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

Major findings: Of operations _____

Of autopsy No

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

Signature John T. Skinner (M. D. or other) M.D.

Address 1402 Bryant Bldg Date signed 4/13/45

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..... *Charles M. Quirk*

Licensed Embalmer No..... *3774*

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.