

V. S. No. 2  
FORM-5-43  
REV. 5-17-39  
I X36877

State File No. ....

**FILED JUN 25 1945**

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 2400

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

(d) Length of stay: In hospital or institution 6 days  
(Specify whether  
In this community Lifetime  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Kansas (b) County Wyandotte 999

(c) City or town Kansas City 14  
(If outside city or town limits, write "RURAL")

(d) Street No. 3208 West 43rd.  
(If rural, give location)

(e) Citizen of foreign country? 2 (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Charles Gerald Safreed

3. (b) If veteran, name war None

3. (c) Social Security No. None

4. Sex male D 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 May 27 1945  
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 2nd.  
year 1945 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from June 1<sup>st</sup>, 1945, to June 2<sup>nd</sup>, 1945;  
that I last saw him alive on June 2<sup>nd</sup>, 1945;  
and that death occurred on the date and hour stated above.

8. AGE:	Years	Months	Days	If less than one day
			<u>58</u>	hr. _____ min.

Immediate cause of death:  
Cerebral infarctus factalis  
obtusis fraxis

Due to RH infarctus

Due to \_\_\_\_\_

9. Birthplace Kansas City No. 1  
(City, town, or county) (State or foreign country)

10. Usual occupation 66--infant

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

Major findings: 161C

Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

11. Industry or business \_\_\_\_\_

MOTHER, FATHER { 12. Name Charles G. Safreed

13. Birthplace no record West Virginia  
(City, town, or county) (State or foreign country)

14. Maiden name AMY E FREEMAN

15. Birthplace K.C. Kans. 1  
(City, town, or county) (State or foreign country)

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?  
\_\_\_\_\_

16. (a) Informant Charles G. Safreed

(b) Address 3208 W. 43rd. Kansas City, Kan.

17. (a) Burial (b) Date thereof 6-5-45  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Forest Hill Cemetery

18. (a) Signature of funeral director Gates Funeral Home

(b) Address 1901 Olathe Blvd. K.C.K.

19. (a) 6-4-45 Geraldine Holmes  
(Date received local registrar) (Registrar's signature)

23. Signature Patrick C. Gredeen M.D. (M. D. or other)  
Address 315 Alameda Rd. KC, Mo. Date signed 6/4/45

**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.....

Licensed Embalmer No. *3991*

P. O. Address..... *309 E. 67 St.*

**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.**