

FILED OCT 23 1945

State File No. _____

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 4193

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town K.C.
(c) Name of hospital or institution:
4619 Warwick 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community 25 yrs years, months or days

3. (a) PRINT FULL NAME JANE F. SOPHIAN

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

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

6. (b) Name of husband or wife Harry J. 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased unknown
(Month) (Day) (Year)

8. AGE: Years 56 Months _____ Days _____ If less than one day hr. _____ min. _____

9. Birthplace M. Y. I
(City, town, or county) (State or foreign country)

10. Usual occupation Homemaker

11. Industry or business _____

12. Name Arthur Felix
13. Birthplace France
(City, town, or county) (State or foreign country)

14. Maiden name Emily Seiter
15. Birthplace Germany
(City, town, or county) (State or foreign country)

16. (a) Informant Jos. Felix

(b) Address N.Y. City

17. (a) Burial (b) Date thereof 10/11/45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Rose Hill Cem.

18. (a) Signature of funeral director Carroll P. Davis

(b) Address 3024 7th St

19. (a) 10-11-45 (b) Maldine Holme
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Jackson
(c) City or town Kansas City
(If outside city or town limits, write "RURAL")
(d) Street No. 4618 Warwick
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 10 day 9
year 1945 hour 12:30 minute P M.

21. I hereby certify that I attended the deceased from _____
to _____
that I last saw him alive on _____
and that death occurred on the date and hour stated above.

Immediate cause of death Fractured neck
Due to Fractured left arm, Fractured right arm
Due to Fall

Other conditions 16 yr
(Include pregnancy within 3 months of death)

Major findings: _____
Of operations _____
Of autopsy no
History + Inspection

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) suicide
(b) Date of occurrence 10-9-45
(c) Where did injury occur? Hill P. Warwick, K.C. Jackson, Mo
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
About home
While at work? no (Specify type of place) (e) Means of injury Fall
23. Signature Jane Sophia (M. D. or other) _____
Address 1424 Poplar Alley Date signed 10-9-45

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

MOTHER FATHER

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

Julian K. Davids

Licensed Embalmer No. *1168*

P. O. Address.....

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.