

UNITED STATES DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
STANDARD CERTIFICATE OF DEATH

36391

State File No. _____

FILED DEC 12 1945

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 4954

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:
General Hospital No. 1
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 17 days
(Specify whether _____)

In this community unknown
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. 1407 Harrison
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Earl Sidle

3. (b) If veteran, name war None

3. (c) Social Security No. 496-05-8850

4. Sex Male

5. Color or race Wh

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

6. (b) Name of husband or wife Naomi

6. (c) Age of husband or wife if alive 46 years

7. Birth date of deceased May 10 1884
(Month) (Day) (Year)

8. AGE: 61 Years Months Days If less than one day
6 3 hr. min.

9. Birthplace Marshall Town Iowa
(City, town, or county) (State or foreign country)

10. Usual occupation Dishwasher

11. Industry or business Arts Lunch

MOTHER FATHER { 12. Name No Record

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

14. Maiden name No Record

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

16. (a) Informant Naomi Sidle

(b) Address 1407 Harrison

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-15-45
(Month) (Day) (Year)

(c) Place: burial or cremation Floral Hills

18. (a) Signature of funeral director [Signature]

(b) Address Kansas City Mo.

19. (a) 12-1-45 (Date received local registrar)

(b) [Signature] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 13
year 1945 hour 8 minute 9 P. M.

21. I hereby certify that I attended the deceased from Oct. 27 1945 to Nov. 13 1945
that I last saw him alive on Nov. 13 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary edema Acute
Cardiac decompensation

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death) 95C

Major findings: _____

Of operations _____

Of autopsy See above

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? _____

23. Signature [Signature] (Specify type of place) _____
(e) Means of injury _____

Address Ed. Dir. Gen'l Hosp. (Date signed) 11-15-45

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

48
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.....

Harold Ross

..... Licensed Embalmer No. *2810*.....

P. O. Address: *17 Ems*.....

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.