

S. No. 2
OM-5-43
ev. 5-17-39
I X36671

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **40258**
Registrar's No. **5223**

FILED JAN 19 1945
Registration District No. 199

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 KANSAS CITY
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
3021 WALROND
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution. (Specify whether)

In this community 8 YEARS
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County JACKSON **48**

(c) City or town KANSAS CITY **3**
(If outside city or town limits, write "RURAL")

(d) Street No. 3021 WALROND **8**
(If rural, give location) **0**

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

If yes, name country _____

3. (a) PRINT FULL NAME ELIZABETH SECHREST

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 LOUIS W SECHREST

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

7. Birth date of deceased DEC 1 1967
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>78</u>	<u>0</u>	<u>16</u>	hr. _____ min.

9. Birthplace TENN. 1
(City, town, or county) (State or foreign country)

10. Usual occupation AT HOME

11. Industry or business _____

12. Name BENHARDT GROSSER 1

13. Birthplace GERMANY 1
(City, town, or county) (State or foreign country)

14. Maiden name UNK. 9

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

16. (a) Informant MRS ALMA REPELL

(b) Address 3021 WALROND, K.C. MO

17. (a) BURIAL (b) Date thereof 12/19/45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation PALESTINE CEM, HICKMAN MILLS

18. (a) Signature of funeral director E.H. Seay

(b) Address Seay's Mo

19. (a) 12-19-45 (b) Thereldine Holmes
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 17
year 1945 hour 1 AM minute 15 AM

21. I hereby certify that I attended the deceased from July 2nd
_____ 1945 to Dec 17 1945;
that I last saw her alive on December 16 1945;
and that death occurred on the date and hour stated above.

Immediate cause of death Cardiac failure due to acute dilatation of right atrium without right atrium

Due to arteriosclerosis

Due to _____

Other conditions none 4
(Include pregnancy within 3 months of death)

Major findings: none 95C 4

Of operations _____

Of autopsy Dilated right atrium

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) none

(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 _____

23. Signature Dr. Gilbert Hartman (M. D. or other) DO

Address 6045 East 15th Date signed 12/17/45

Duration _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

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. 3645

P. O. Address. Granville 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.