

No. 2
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5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

41436

STANDARD CERTIFICATE OF DEATH

State File No.

FILED JAN 5 1946

Registration District No.

Primary Registration District No. 5575

Registrar's No. 88

1. PLACE OF DEATH:

(a) County Jackson
 (b) City or town Kansas City (Rural)
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: 8516 Wayne
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution
 In this community 37 yrs
 years, months or days (Specify whether)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Jackson
 (c) City or town Kansas City - Rural
 (If outside city or town limits, write "RURAL")
 (d) Street No. 8516 Wayne
 (If rural, give location)
 (e) Citizen of foreign country? No (Yes or No)
 If yes, name country

3. (a) PRINT FULL NAME Carman (Pete) Santhoff

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

4. Sex Male 5. Color or race Wh 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Ona Santhoff 6. (c) Age of husband or wife if alive 63 years

7. Birth date of deceased March 29th 84
 (Month) (Day) (Year)

8. AGE: Years 61 Months 8 Days 27 If less than one day
 hr. min.

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

10. Usual occupation R. R. Switchman

11. Industry or business Ret. 7yrs.

12. Name William anthoff

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

14. Maiden name Florence Walton

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

16. (a) Informant Ona Santhoff

(b) Address 8516 Wayne

17. (a) Burial (b) Date thereof 11-28-45
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mo. Washington

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

(b) Address 7406 Wernall Rd

19. (a) 11/28/45 (b) Dr. Annie B. Nedge
 (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 26
 year 1945 hour 10 minute 20 P.M.

21. I hereby certify that I attended the deceased from Nov. 3, 1945
 to Nov. 26, 1945
 that I last saw him alive on Nov. 26, 1945
 and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia
 Due to Asthma
 Duration 24 hrs
15 yrs

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy none

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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 work) (If means of injury)
 Signature [Signature] (M. D. or other)
 Address 408 1/2 W. 15 Date signed 11/29/45

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

1152

(Licensed Embalmer's Statement on Reverse Side)

JUL 23 1941

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 Roe*

Licensed Embalmer No. *2570*

P. O. Address *S. E. 14*

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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

Registration District No. 154

Primary Registration District No. 5-5-75

Registrar's No. 88

1. PLACE OF DEATH

(a) County Jackson
(b) City or town Lansing City Rural
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:

(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether
In this community _____ years, months or days)

3. (a) PRINT FULL NAME Carron (Pete) Southoff

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

4. Sex M 5. Color or race w 6. (a) Single, widowed, married, divorced m

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

7. Birth date of deceased Mar 29 1945
(Month) (Day) (Year)

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

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

10. Usual occupation _____

11. Industry or business _____

12. Name _____

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

14. Maiden name _____

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

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ Day _____
year 1945 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 19____;
that I last saw him _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.
Immediate cause of death _____

Bronchial Pneumonia - 36 hrs.
regional
Due to _____
Due to _____

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

Major findings: Of operations _____
Of autopsy 107
ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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) _____
Means of injury _____
23. Signature Geo. F. Clark (M.D. or other) _____
Address 208 W. 75th Date signed 2-23-46

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

SUPPLEMENTARY

41436