

No. 2
M-5-43
5-17-39
I X36671

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **13429**
Registrar's No. **1929**

FILED MAY 6 1946

Registration District No. **47** Primary Registration District No. **1002**

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:
Northeast Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 day
(Specify whether years, months or days)

In this community 1 day
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Scuyler Colfax Werntz

3. (b) If veteran, name war no

3. (c) Social Security No. none

4. Sex Male 5. Color or race White

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

6. (b) Name of husband or wife Mary Werntz

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

7. Birth date of deceased 8/13/1866
(Month) (Day) (Year)

8. AGE:

| | | | |
|-----------|----------|-----------|----------------------|
| Years | Months | Days | If less than one day |
| <u>79</u> | <u>8</u> | <u>11</u> | hr. min. |

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

10. Usual occupation Shoemaker

11. Industry or business Retired

12. Name John Werntz

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

14. Maiden name Cordelia Skyles

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

16. (a) Informant O. F. Werntz

(b) Address East Lynne, Mo.

17. (a) Removal (b) Date thereof 4/24/46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation East Lynne, Mo.

18. (a) Signature of funeral director John P. Sheil

(b) Address Kansas City, Mo.

19. (a) 4-25-46 (b) Geraldine Holms
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Jackson

(c) City or town East Lynne
(If outside city or town limits, write "RURAL")

(d) Street No. --
(If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 24
year 1946 hour 2 minute _____ P. M.

21. I hereby certify that I attended the deceased from April 23, 1946 to 4-24, 1946
that I last saw her alive on 4-24, 1946
and that death occurred on the date and hour stated above.

Immediate cause of death Perforation of ascending colon

Due to metastatic carcinoma of ascending colon

Due to Septicemic carcinoma of sigmoid colon

Other conditions Sigmoid colon
(Include pregnancy within 3 months of death)

Duration 4-24-46

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

Major findings:
Of operations _____

Of autopsy as above

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)

(e) Means of injury _____

23. Signature G. H. ... (M. D. or other) 2 DO
Address ... City, Mo. Date signed 4/24/46

WRITE PLAINLY—USE UNFADING INK—MAKE A PERMANENT RECORD

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 John P. Scheil
Licensed Embalmer No. 3625
P. O. Address Kansas City 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.