

No. 2
-12-45
-17-39
X4707

FILED SEP 9 1946
Registration District No. 177

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: Menorah Hospital 0
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 week
(Specify whether in this community years, months or days)

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

3. (a) PRINT FULL NAME CARL J. EICHENAUER

3. (b) If veteran, name war. No

3. (c) Social Security No. 7107E

4. Sex Ma 0 5. Color or race Wh

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

6. (b) Name of husband or wife Helen E. Eichenauer

6. (c) Age of husband or wife if alive 68 years

7. Birth date of deceased: July 28 1877
(Month) (Day) (Year)

8. AGE: Years 69 Months 1 Days 1
If less than one day hr. min.

9. Birthplace Kansas City Mo. 0
(City, town, or county) (State or foreign country)

10. Usual occupation Post Office Clerks

11. Industry or business K.C. General Post Office

MOTHER FATHER { 12. Name John C. Eichenauer

13. Birthplace Germany 4
(State or foreign country)

14. Maiden name Wingnereta Doering

15. Birthplace Germany 11
(City, town, or county) (State or foreign country)

16. (a) Informant Gertrude Eichenauer

(b) Address 4330 Jarboe

17. (a) Burial (b) Date thereof: 9-3-46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Forest Hill

18. (a) Signature of funeral director J.W. Wagner
Kansas City, Mo.

(b) Address

19. (a) 8-30-46 (b) Sheldine Holmes
(Date received local registrar) (Registrar's signature)

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. 4330 Jarboe 8
(If rural, give location)

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

If yes, name country.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. day 29
year 1946 hour 11: minute 35 P. M.

21. I hereby certify that I attended the deceased from 8-22 1946 to 8-29 1946
that I last saw him live on 8-29 and that death occurred on the date and hour stated above.

Immediate cause of death

Cerebral anemia 24 hrs
and convulsions

Due to Heart block 6 hrs

Other conditions 950
(Include pregnancy within 3 months of death)

Major findings: 950

Of operations

Of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

(c) 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 Allois S. Smith MD
4 20 Prof Bess (M. D. or other)

Date signed 8-30-46

OCT 2 1905

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 Alvin R. Hainschild

Licensed Embalmer No. 4159

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.