

FILED JUN 14 1947

Registration District No. **150**

Primary Registration District No. **5572**

1. PLACE OF DEATH:

(a) County **Jackson**
(b) City or town **Rural Prairie**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **Jackson County Emg. Hospital**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **5 days** (Specify whether
In this community **Unknown** years, months or days)

2. USUAL RESIDENCE OF DECEASED:

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

3. (a) PRINT FULL NAME **Andrew Jackson Zumwalt**

3. (b) If veteran name was **Unknown** 3. (c) Social Security **Unknown**

4. Sex **Male** 5. Color or race **wh.** 6. (a) Single, widowed, married, divorced **married**
6. (b) Name of husband or wife **Unknown** 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased **Unknown** (Month) (Day) (Year)

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

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

10. Usual occupation **Laborer**

11. Industry or business **Farm**

12. Name **Unknown** **9**

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

14. Maiden name **Unknown** **9**

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

16. (a) Informant **Records of Jackson Co. Mort.**

(b) Address **P.R. 4 Independence Mo**

17. (a) **Anatomical** (b) Date thereof **6-4-47** (Month) (Day) (Year)

(c) Place: burial or cremation **K.C. Univ. Dental**

18. (a) Signature of funeral director **N. Chaney**

(b) Address **Lees Summit Mo.**

19. (a) **6-4-47** (Date received local registrar) (b) **Ronald C. Emslow** (Registrar's signature) **879**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **May** day **28th** year **1947** hour **8** minute **00 P.** M.

21. I hereby certify that I attended the deceased from **5-24-47** 19. to **5-28-47** 19. that I last saw him alive on **5-28-47** and that death occurred on the date and hour stated above.

Immediate cause of death **Cerebral hemorrhage** Duration **5 days**

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death)

Major findings: **437A**
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? _____

(e) Signature **Frank E. Treharsh** (Specify, if of place) (f) Means of injury _____

Address **Indep Mo** Date signed **6/3/47**

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

48
0
0

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.....

P. O. Address.....

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.