

THE STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

FILED AUG 5 1947
Registration District No. 1002

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:
General Hospital No. 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 4 days (Specify whether
In this community 1 year
years, months or days)

3. (a) PRINT FULL NAME William Engleman

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 SINGLE
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive 2 years (Day) (Year) 1860

7. Birth date of deceased Oct. 1860
(Month) (Day) (Year)

8. AGE: Years 86 Months 9 Days ? If less than one day hr. min.

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

10. Usual occupation RET. FARMER

11. Industry or business
12. Name JACOB ENGLEMAN
13. Birthplace Ky
(City, town, or county) (State or foreign country)
14. Maiden name MARY HICKMAN
15. Birthplace Ky
(City, town, or county) (State or foreign country)

16. (a) Informant MRS. O. N. WHITE
(b) Address #1 LEES SUMMIT, MO.

17. (a) Burial (b) Date thereof July 19, 1947
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation BALTON, MO.

18. (a) Signature of funeral director G. N. Sumpster
(b) Address GRANDVIEW MO.

19. (a) 7-19-47 (b) Geraldine Holmes
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County JACKSON
(c) City or town GRANDVIEW
(If outside city or town limits, write "RURAL")
(d) Street No. 1
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 18
year 1947 hour 5 minute 20 A.M.

21. I hereby certify that I attended the deceased from July 14, 1947 to July 18, 1947;
that I last saw him alive on July 18, 1947;
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral thrombosis

Due to
Due to

Other conditions (Include pregnancy within 3 months of death) 835

Major findings: Of operations
Of autopsy None

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 Wm W. Hart (M. D. or other) MD
Med. Dir. Gen'l Hosp. (Date signed) 7-18-47
Address Date signed

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

MOTHER FATHER

Dr. Landis

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..... *A R Geomp*

Licensed Embalmer No. *3645*

P. O. Address. *GRANDVIEW, 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.