

S. No. 2  
DM-5-43  
v. 5-17-39  
I X36671

FILED DEC 15 1947  
Registration District No. **749**

Primary Registration District No. **1002**

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

1. PLACE OF DEATH:

(a) County **Jackson City Mo.**

(b) City or town **Jackson City Mo.**  
(Outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: **St. Luke's 0**  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **4 days** (Specify whether years, months or days)

In this community **4 days**

2. USUAL RESIDENCE OF DECEASED:

(a) State **Kans.** (b) County **Miami 999**

(c) City or town **Paola 14**  
(If outside city or town limits, write "RURAL")

(d) Street No. **105 S. Second 0**  
(If rural, give location)

(e) Citizen of foreign country? **no.** (Yes or No)

If yes, name country **2**

3. (a) PRINT FULL NAME **MARGARET Prothe**

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 **2**

6. (b) Name of husband or wife **unknown**

6. (c) Age of husband or wife if alive **27** years

7. Birth date of deceased **Dec. 27 1866**  
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Dec.** day **2**  
year **1947** hour **2** minute **45** A.M.

21. I hereby certify that I attended the deceased from **Nov. 27**  
**1947**, to **Dec. 2**, 19**47**.

that I last saw her alive on **Dec. 1**, 19**47**,  
and that death occurred on the date and hour stated above.

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

**80 11 5** hr. min.

Immediate cause of death **Coronary thrombosis**

Due to **arteriosclerosis**

Due to

Other conditions (Include pregnancy within 3 months of death)

9. Birthplace **Miami Co. Kans.**  
(City, town, or county) (State or foreign country)

10. Usual occupation **None**

PHYSICIAN

Major findings: **942**

Of operations

Of autopsy

Underline the cause to which death should be charged statistically.

MOTHER FATHER

11. Industry or Business

12. Name **Martin Kitzing 4**

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

14. Maiden name **Cathy Dickinson**

15. Birthplace **Germany 4**  
(City, town, or county) (State or foreign country)

16. (a) Informant **Hessman Prothe**

(b) Address **Paola Kans.**

17. (a) **Removal** (Burial, cremation, or removed) (b) Date thereof **12-2-47**  
(Month) (Day) (Year)

(c) Place: burial or cremation **St. Paul Paola Kans.**

18. (a) Signature of funeral director **Ray K. ...**

(b) Address **Paola Kans.**

19. (a) **12-3-47** (Date received local registrar) (b) **St. Geraldine Holmes** (Registrar's signature)

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 **0**

23. Signature **Roy R. Coffey** (M. D. or other)

Address **225 S. ST. Luke's Hosp.** Date signed **12-2-47**

1948 JUN 3 11:48

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.....

*Charles L. Carlson*

....., Registered Apprentice No.....

working under my personal supervision.

Signed.....

*Charles L. Carlson*

Licensed Embalmer No. *911*.....

P. O. Address *Osola, Kansas*.....

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.