

No. 300  
-10-47  
5-17-39  
I 2906

FILED SEP 18 1948 49  
Registration District No. \_\_\_\_\_

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: St. Mary's Hospital  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 21 hours  
(Specify whether years, months or days)

In this community 12 years  
(Specify whether years, months or days)

**3: (a) PRINT FULL NAME** MRS. MARGARET K. FENSKE

3. (b) If veteran, name war XX

3. (c) Social Security No. None

4. Sex Fe 5. Color or race Wh

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

6. (b) Name of husband or wife Otto Fenske

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

7. Birth date of deceased August 13 1882  
(Month) (Day) (Year)

| 8. AGE: | Years     | Months   | Days      | If less than one day |
|---------|-----------|----------|-----------|----------------------|
|         | <u>66</u> | <u>0</u> | <u>26</u> | hr. _____ min. _____ |

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

10. Usual occupation At Home

11. Industry or business \_\_\_\_\_

12. Name No Record

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

14. Maiden name \_\_\_\_\_

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

16. (a) Informant Otto Fenske

(b) Address 601 E. 70th Terrace

17. (a) Burial  
(Burial, cremation, or removal)

(b) Date thereof 9-13-48  
(Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director J. W. Wagner

(b) Address Kansas City, Mo.

19. (a) 9-11-48  
(Date received local registrar)

(b) Cleraldine Holmes  
(Registrar's signature)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Missouri (b) County Jackson

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

(d) Street No. 3012 Gillham Road  
(If rural, give location)

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

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month August day 9th  
year 1948 hour 10: minute 10 P. M.

21. I hereby certify that I attended the deceased from June 6  
1948 to Sept 9 1948  
that I last saw ek alive on Sept 9 1948  
and that death occurred on the date and hour stated above.

Immediate cause of death Cardiac failure  
Auricular fibrillation  
Colloid goiter  
Pollaki

Due to General malnutrition

Other conditions General malnutrition  
(Include pregnancy within 3 months of death)

Major findings:  
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:

(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)

(c) Means of injury \_\_\_\_\_

23. Signature Michael R. ... (M. D. or other) M.D.

Address 436 Professional Bldg Date signed 9-11-48

(Hand)  
71.4-0266

---

---

**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.....

Eugene L Kennon....., Registered Apprentice No. 217  
working under my personal supervision.

Signed Alvin B. Harnschke

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.**