

FILED JAN 12 1949

Registration District No. **280**

Primary Registration District No. **6964**

Registrar's No. **25**

1. PLACE OF DEATH: **Platte Rural**

(a) County **Platte**

(b) City or town **Rural**  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: **R7D 3 Parkville, Mo. 1**  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **75 years**  
(Specify whether years, months or days)

In this community **75 years**

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County **Platte** **83**

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

(d) Street No. **6 mi. N. E. Parkville**  
(If rural, give location)

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

If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME **Charles Woehl**

3. (b) If veteran, name war **no**

3. (c) Social Security No. **no**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Dec** day **27**  
year **1948** hour **4** minute **A** M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;  
that I last saw him alive on \_\_\_\_\_ and that death occurred on the date and hour stated above.

4. Sex **Male** 5. Color **White**

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

6. (b) Name of husband or wife \_\_\_\_\_

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

7. Birth date of deceased: **March, 10 1873**  
(Month) (Day) (Year)

Immediate cause of death: **Coronary Occlusionary**

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

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

75	9	17	hr. _____ min.
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9. Birthplace **Parkville Mo**  
(City, town, or county) (State or foreign country)

10. Usual occupation **Farmer**

PHYSICIAN

Major findings: Of operations \_\_\_\_\_

Of autopsy **By 40**

Underline the cause to which death should be charged statistically.

MOTHER FATHER

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

12. Name **Michel Woehl** **5**

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

14. Maiden name **Catherine Wagons**

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

16. (a) Informant **Adam Woehl**

(b) Address **Palola Kansas**

17. (a) **Burial** (b) Date thereof **Dec 29 1948**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Bury. Cons.**

18. (a) Signature of funeral director **Leah H. Francis**

(b) Address **Parkville Mo**

19. (a) **12-27-48** (b) **Opina Ralston**  
(Date received local registrar) (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 **3**

23. Signature **Tom H. Hullett** **Coroner**  
(St. D. or other)

Address **Platte City Mo** Date signed **12-27-48**

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

RECEIVED

District Health Officer No. 8,

District File Number \_\_\_\_\_

Date Filed 1-11-49

**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 Leland H. Francis

Licensed Embalmer No. 3451

P. O. Address Parkville 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.