

MISSOURI STATE BOARD OF HEALTH
 STANDARD CERTIFICATE OF DEATH

State File No. 1339
 Registrar's No. 324

Registration District No. 399

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:
K.C. General Hospital No. 1
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 14 days
 (Specify whether
 In this community Unknown
 years, months or days)

3. (a) PRINT FULL NAME ALBERT EDWARDS 363

3. (b) If veteran, name war no 3. (c) Social Security No. 910

4. Sex male 5. Color or race white 6. (a) Single, widowed, married, divorced unknown

6. (b) Name of husband or wife unknown 6. (c) Age of husband or wife if alive unknown years

7. Birth date of deceased Unknown
 (Month) (Day) (Year)

8. AGE: Years app. 55 Months Days If less than one day
 hr. min.

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

10. Usual occupation Laborer

11. Industry or business Retired

12. Name unknown

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

14. Maiden name unknown

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

16. (a) Informant's own signature dean stark

(b) Address K. C. Mo

17. (a) Burial (b) Date thereof Jan 24-40
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Green Lawn

18. (a) Signature of funeral director A. C. Doshler

(b) Address 1415 E. 15

19. (a) Jan. 23, 1940 (b) M. V. Kerome
 (Date received local registrar) (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. 702 East 15th St., K.C. Mo.
 (If rural, give location)
 (e) If foreign born, how long in U. S. A. unknown years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 18th
 year 1940 hour 12 minut 50 P. M.

21. I hereby certify that I attended the deceased from 1-4-40, 19 , to 1-18-40, 19 ;
 that I last saw him alive on 1-18-40, 19 ;
 and that death occurred on the date and hour stated above.

Immediate cause of death Myocardial insufficiency
 Duration 92

Due to _____
 Due to _____

Other conditions None
 (Include pregnancy within 3 months of death)

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 1

23. Signature Dr. De Maria MD (M. D. or other)
 Address Supt. K.C. Gen. Hospital Date signed 1-19-40

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

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

1 X1951

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, above space should be left blank.