

Registration District No. 399Primary Registration District No. 1002Registrar's No. 448

## 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. 2.  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 1-13-40-1-21-40  
(Specify whether  
 In this community 20 years  
years, months or days)

3. (a) PRINT FULL NAME V argos Serepiro 6/163. (b) If veteran, name war Unk. 3. (c) Social Security No. Unk.4. Sex Male 5. Color or race Mexican 6. (a) Single, widowed, married, divorced Single6. (b) Name of husband or wife -- 6. (c) Age of husband or wife if alive -- years7. Birth date of deceased Unknown  
(Month) (Day) (Year)8. AGE: Years Months Days If less than one day  
About 55 hr. min.9. Birthplace Old Mexico  
(City, town, or county) (State or foreign country)10. Usual occupation none 3

11. Industry or business

12. Name unknown 9  
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 Record Clerk(b) Address General Hospital No. 2.17. (a) Anatomical (b) Date thereof Jan 29 40  
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation Western Dental College18. (a) Signature of funeral director Wailert Funeral Home(b) Address 2332 Monitor Place K. C. Mo19. (a) Jan. 30, 1940 (b) M. M. Crowe  
(Date received local registrar) (Registrar's signature)

## 2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Jackson  
 (c) City or town Kansas City  
(If outside city or town limits, write "RURAL")  
 (d) Street No. Helping Hand (514 Grand)  
(If rural, give location)  
 (e) If foreign born, how long in U. S. A.? 20 years years.

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 1 day 21  
year 40 hour 8 minute 30 P.M.21. I hereby certify that I attended the deceased from 1-13- 19 40 to 1-21- 19 40  
that I last saw him alive on 1-21- 19 40  
and that death occurred on the date and hour stated above.Immediate cause of death Garcinoma of G. I. Tract  
Probable diagnosis  
Due to not confirmed by autopsy DurationDue to  
Other conditions Parosis - Syphilis  
(Include pregnancy within 3 months of death)Major findings:  
Of operations 83  
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) (e) Means of injury \_\_\_\_\_

23. Signature [Signature] (M. D. or other)  
Address General Hospital #2 Date signed 1-22

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**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.....

*Blaine E. Wilcut*

Licensed Embalmer No.....

*4075*

P. O. Address.....

*2332 Montau, Ill.*

**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.**