

Registration District No. **FILED MAR 19 1940**

Primary Registration District No. **1002**

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. PLACE OF DEATH:
 (a) County Jackson
 (b) City or town Kansas City
 (c) Name of hospital or institution: General Hospital #2
 (d) Length of stay: In hospital or institution 2-1-40-2-7-40
 In this community 13 years

2. USUAL RESIDENCE OF DECEASED:
 (a) State Mo. (b) County Jackson
 (c) City or town Kansas City
 (d) Street No. 2812 Myrtle Ave.
 (e) If foreign born, how long in U. S. A. _____ years.

3. (a) PRINT NAME Norman E. Stevenson
 (b) If veteran, name war None
 (c) Social Security No. None

4. Sex Male 5. Color or race Negro 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 11 22 1926
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
13 2 15 _____ hr. _____ min.

9. Birthplace Kansas City Missouri
 (City, town, or county) (State or foreign country)
 10. Usual occupation Student

11. Industry or business _____
 12. Name Napoleon Stevenson
 13. Birthplace Tennessee
 (City, town, or county) (State or foreign country)
 14. Maiden name Helen White
 15. Birthplace Mo.
 (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Record Clerk
 (b) Address General Hospital #2
 17. (a) burial (b) Date thereof 2-10-40
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Highland Cemetery
 18. (a) Signature of funeral director Hatkins Bros
 (b) Address 1729 Lydia
 19. (a) Feb. 10, 1940 (b) M. M. Crowe
 (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month 2 day 7
 year 40 hour 3 minute 55 A. M.
 21. I hereby certify that I attended the deceased from 2-1- 19 40 to 2-7- 19 40
 that I last saw him alive on 2-7- 19 40
 and that death occurred on the date and hour stated above.

Immediate cause of death Ruptured Appendix.
 Due to 121
 Due to _____
 Other conditions (include pregnancy within 3 months of death) _____
 Major findings: _____
 Of operations _____
 Of autopsy _____

Duration
 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 J. E. Jones (M. D. or other)
 Address General Hospital #2 Date signed 2-8-40

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: *Isaac Jerome Mauler*

Licensed Embalmer No. *3994*

P. O. Address *1150 E 23rd St*

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.