

Registration District No. 399

Primary Registration District No. 1002

Registrar's No. 1364

1. PLACE OF DEATH:
 (a) County Jackson
 (b) City or town Kansas City
 (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 19 days
 In this community 11 years
 years, months or days) (Specify whether)

3. (a) PRINT FULL NAME JAMES MADISON ANDREWS 53b
 3. (b) If veteran, name war No
 3. (c) Social Security No. No

4. Sex Male
 5. Color or race Wh
 6. (a) Single, widowed, married, divorced Married
 6. (b) Name of husband or wife Mrs. Lucy S. Andrews
 6. (c) Age of husband or wife if alive 72 years
 7. Birth date of deceased July 26 1862
 (Month) (Day) (Year)

8. AGE: Years 77 Months 8 Days 1
 If less than one day hr. min.

9. Birthplace Clay County Missouri
 (City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business _____
 12. Name Alfred Andrews
 13. Birthplace So. Carolina
 14. Maiden name Marinda Strater
 15. Birthplace Missouri
 (City, town, or county) (State or foreign country)

16. (a) Informant Mrs. C. S. Swanson
 (b) Address 4145 Locust

17. (a) Burial (b) Date thereof 3-29-40
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Lawson, Mo.

18. (a) Signature of funeral director M. Wagner
 (b) Address Kansas City, Mo.

19. (a) Mch 28, 1940 (b) M. M. Crowe
 (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. 4145 Locust
 (If rural, give location)
 (e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month March day 27,
 year 1940 hour 3 minute :05 P. M.

21. I hereby certify that I attended the deceased from Mar 18
 1940, to Mar 27 1940.
 that I last saw him alive on Mar 27 1940.
 and that death occurred on the date and hour stated above.

Immediate cause of death Heart disease
arrhythmia fibrillation
which he had had for some time
 Due to Complicated by SI
operation
 Due to hemorrhoidal prostatic
necrosis - Cancer of Prostate
 Other conditions _____
 (Include pregnancy within 3 months of death)

PHYSICIAN _____
 Major findings: _____
 Of operations _____
 Of autopsy None
 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) no
 (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 Clarence Capall (M. D. or other) _____
 Address 1137 Walnut St. St. Louis Date signed 3/28

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

Dr. Capell

Rialto,

VI 9594

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 Carl R. Matthes

Licensed Embalmer No. 3807

P. O. Address 9 e 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, above space should be left blank.