

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.

Registration District No. 399

Primary Registration District No. 1002

Registrar's No. 1424

1. PLACE OF DEATH:

(a) County Jackson
 (b) City or town Kansas
(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 1 day
(Specify whether
 In this community No record
years, months or days)

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. 555 1/2 Walnut, Apt. #8
(If rural, give location)
 (e) If foreign born, how long in U. S. A. _____ years.

3. (a) PRINT FULL NAME Price, Asbury

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

4. Sex Male 5. Color or race W. 6. (a) Single, widowed, married, divorced No record

6. (b) Name of husband or wife No record 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased No record
(Month) (Day) (Year)

8. AGE: Years about 70 yrs Months No Days record If less than one day _____ hr. _____ min.

9. Birthplace No record
(City, town, or county) (State or foreign country)

10. Usual occupation No record

11. Industry or business _____

12. Name No record

13. Birthplace No record
(City, town, or county) (State or foreign country)

14. Maiden name No record

15. Birthplace No record
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Record Clerk

(b) Address K.C. Gen. Hosp., K.C. Mo.

17. (a) Removal (b) Date thereof 4 1 40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Kirksville, Missouri

18. (a) Signature of funeral director Wailert Funeral Home

(b) Address 2332 Monitor Place, Kc Mo.

19. (a) April 1, 1940 (b) M. M. Brame
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 17th
 year 1940 hour 1 minute 25 A.M. M.

21. I hereby certify that I attended the deceased from 3-16-40 to 3-17-40
 that I last saw him alive on 3-17-40
 and that death occurred on the date and hour stated above.

Immediate cause of death Chronic nephritis with uremia

Due to 121

Due to _____

Other conditions (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? 361

While at work? _____ (e) Means of injury _____

23. Signature D. F. ... M.D. (M. D. or other)
 Address D. F. ... Hospital, K.C. Mo. Date signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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. Wilcox

Licensed Embalmer No.

4075

P. O. Address

2332 Newton 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.