

**AUG 14 1940**

Registration District No. 399

Primary Registration District No. 1002

Registrar's No. 2685

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

1. PLACE OF DEATH:

(a) County Jackson  
(b) City or town Kansas City  
(c) Name of hospital or institution: Trinity Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 15 years  
(Specify whether years, months or days)

8. (a) PRINT FULL NAME Irving L. Carpenter 615

8. (b) If veteran, name war none  
8. (c) Social Security No. 495-03-0688

4. Sex Male  
5. Color or race White  
6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Mrs. Alma Ogden Carpenter alive 54 years  
6. (c) Age of husband or wife if

7. Birth date of deceased April 9, 1890  
(Month) (Day) (Year)

8. AGE: Years 50 Months 2 Days 25  
If less than one day hr. min.

9. Birthplace Salem, New York  
(City, town, or county) (State or foreign country)

10. Usual occupation Linotype Operator

11. Industry or business 9

MOTHER FATHER { 12. Name George W. Carpenter 9  
18. Birthplace Don't Know 6  
(City, town, or county) (State or foreign country)

{ 14. Maiden name Don't Know  
15. Birthplace Don't Know  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Alma Ogden Carpenter  
(b) Address 39 West 73rd St. Terrace

17. (a) Burial (b) Date thereof 7-6-40  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Forest Hill

18. (a) Signature of funeral director Freeman Mortuary  
(b) Address Kansas City, Missouri

19. (a) July 5, 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. 39 West 73rd Terrace  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 4th  
year 1940 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from 6-14, 1940, to 7-4, 1940.

that I last saw him alive on 7-4, 1940, and that death occurred on the date and hour stated above.

Immediate cause of death Acute dilatation of heart Duration \_\_\_\_\_

Due to Acute myocarditis

Due to Acute cholecystitis 21 days

Other conditions: 9500  
(Include pregnancy within 4 months of death)

Major findings: Acute cholecystitis PHYSICIAN \_\_\_\_\_

Of operations \_\_\_\_\_  
Of autopsy Same  
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 1

23. Signature John P. Lawrence (M. D. or other) \_\_\_\_\_  
Address Lathrop Bldg. R.E.M. Date signed 7-4-40

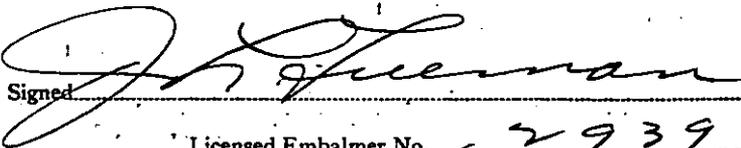
100

11-17

---

**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. 2939

P. O. Address K.C. 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.**