S. No. 2
—11-10-39
r. 5-17-39
I X21492

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

AUG 14 1940

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 24157

Registration District No. 399 — Primary Registration District No. 1002 — Registrar's No. 2767

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: Continental Hotel, Room 2016
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution: no. (Specify whether years, months or days)
In this community: 10 years

2. USUAL RESIDENCE OF DEACESED:
(a) State: Missouri (b) County: Jackson,
(c) City or town: Kansas City,
(If outside city or town limits, write "RURAL")
(d) Street No.: Continental Hotel, Room 2016
(If rural, give location)
(e) If foreign born, how long in U. S. A.? ____ years.

3. (a) PRINT FULL NAME: Charles W. Partridge, 63/6
3. (b) If veteran, name war: No. — 484-09-6939
3. (c) Social Security No.: No.
4. Sex: Male
5. Color or race: White
6. (a) Single, widowed, married, divorced: Single
6. (b) Name of husband or wife: x
6. (c) Age of husband or wife if alive: x years
7. Birth date of deceased: May (Month) 4th, (Day) 1890 (Year)
8. AGE: Years 50 | Months 2 | Days 4 | If less than one day ____ hr. ____ min.
9. Birthplace: Illinois, (City, town, or county) (State or foreign country)
10. Usual occupation: Secretary,
11. Industry or business: Operative Millers,
FATHER 12. Name: Charles A. Partridge,
FATHER 13. Birthplace: Vermont, (City, town, or county) (State or foreign country)
MOTHER 14. Maiden name: Jane Earle,
MOTHER 15. Birthplace: Vermont, (City, town, or county) (State or foreign country)
16. (a) Informant: Robin McGeorge,
(b) Address: Continental Hotel, K. C., Mo.
17. (a) Removal (Burial, cremation, or removal) (b) Date thereof: 7-9-40 (Month) (Day) (Year)
(c) Place: burial or cremation: LaGrange, Illinois.
18. (a) Signature of funeral director: Stine & McClure,
(b) Address: 3235 Gillham Plaza, K. C., Mo.
19. (a) July 9, 1940 (Date received local registrar) (b) M. M. Grove (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 8th, year 1940 hour 11:50 minute A M.
21. I hereby certify that I attended the deceased from Sept. 9, 1934, 19__, to May 25, 1940; that I last saw him alive on May 25, 1940; and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Heart Block	Few min.
Due to: Hypertensive Heart Disease & Bundle Branch Block	6-7 years.
Due to:	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
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? (Specify type of place)
While at work? (e) Means of injury

23. Signature: Harold M. Roberts (M. D. or other) M.D.
Address: 1103 Grand Ave., K.C.Mo. Date signed 7-8-40

(Licensed Embalmer's Statement on Reverse Side)

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

Dewey Towns, Registered Apprentice No. 222

working under my personal supervision.

Signed E. M. Plowes

Licensed Embalmer No. 1848

P. O. Address K. C. Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply w the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.