

FILED SEP 5 1940
1940
Registration District No. **299**

Primary Registration District No. **1002**

Registrar's No. **3286**

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:
General Hospital #2
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **8-12-40-8-12-40**
(Specify whether
In this community **30 years**
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo.** (b) County **Jackson**
(c) City or town **Kansas City**
(If outside city or town limit, write "RURAL")
(d) Street No. **1916 Troost Ave.**
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

3. (a) PRINT FULL NAME **Clafflin Alford** **416**

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

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

6. (b) Name of husband or wife **Edith Alford** 6. (c) Age of husband or wife if alive **Unknown** years

7. Birth date of deceased **11 23 1892**
(Month) (Day) (Year)

8. AGE: Years **48** Months **8** Days **20** If less than one day hr. min.

9. Birthplace **Merrouge La.**
(City, town, or county) (State or foreign country)

10. Usual occupation **Laborer**

11. Industry or business **9**

12. Name **Unknown** **9**

13. Birthplace **Unknown**
(City, town, or county) (State or foreign country)

14. Maiden name **Unknown** **9**

15. Birthplace **Unknown**
(City, town, or county) (State or foreign country)

16. (a) Informant **Record Clerk**
(b) Address **General Hospital #2**

17. (a) **Burial** (b) Date thereof **8-20-40**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Lincoln Cemetery**

18. (a) Signature of funeral director **J. W. Mc Coy**

(b) Address **1513 Troost**

19. (a) **Aug. 20, 1940** (b) **Mo. M. Crave**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **8** day **12**
year **40** hour **11** minute **15 P. M.**

21. I hereby certify that I attended the deceased from **8-12-**, 19 **40** to **8-12-**, 19 **40**

that I last saw him alive on **8-12-**, 19 **40**
and that death occurred on the date and hour stated above.

Immediate cause of death: **Traumatic Shock with Hemorrhage**

Due to **Ruptured Intestine Secondary to Foreign Body.**

Due to **(Glass bottle inserted in rectum)**

Other conditions **N. M. O.**
(Include pregnancy within 3 months of death)

Major findings: **195**
Of operations **97**

Of autopsy _____

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? **3/1**

While at work? _____ (Specify type of place)
(e) Means of injury **!**

23. Signature **W. C. Sumner** (M. D. or other)

Address **Gen. Hosp. #2** Date signed **8-13-40**

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

MOTHER FATHER

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.....

L. J. Harris, Sr.

Licensed Embalmer No. 3388

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.