

Registration District No. 399

Primary Registration District No. 1002

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

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: 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 16 years
years, months or days)

3. (a) PRINT FULL NAME JAMES S. TERRILL

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

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

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

7. Birth date of deceased May 6 1900
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>40</u>	<u>3</u>	<u>24</u>	hr. <u> </u> min. <u> </u>

9. Birthplace Marcelene MO
(City, town, or county) (State or foreign country)

10. Usual occupation Laborer-W.P.A.

11. Industry or business

12. Name Charles Terrill

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

14. Maiden name Hattie Jagers

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

16. (a) Informant Thos Wm McBrien

(b) Address 1415 Central

17. (a) Buried (b) Date thereof 9/3/40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Wadsworth Road

18. (a) Signature of funeral director Mayberry Funeral Bg.

(b) Address 2315 Fundamental

19. (a) Sept. 2, 1940 (Date received local registrar) M. M. Brown (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 limit, write "RURAL")
(d) Street No. 3404 E. 12th St.
(If rural, give location)
(e) If foreign born, how long in U. S. A. years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. day 30th
year 1940 hour 5 minute 50 A.M. M.

21. I hereby certify that I attended the deceased from 8-29-40, 19 , to 8-30-40, 19 ;

that I last saw him alive on 8-30-40, 19 ; and that death occurred on the date and hour stated above.

Immediate cause of death Subdural and subpial hemorrhage left cerebellar lobe

Due to
Due to

Other conditions Acute pulmonary congestion and edema
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy See above

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

23. Signature Dwight R. Stone (M. D. or other)
Address Med. Dir. K.C. Gen. 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

Ray C. Snow

Licensed Embalmer No. 2560

P. O. Address 1807 East 29th

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.