

No. 2
-10-39
17-39
X21

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:
General Hospital #2
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 9-1-40-9-2-40
(Specify whether
In this community 17 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 limits, write "RURAL")
(d) Street No. 1309 1/2 E. 14th St.
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

3. (a) PRINT FULL NAME Alice Douglas

3. (b) If veteran, name war None 3. (c) Social Security No. None

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

6. (b) Name of husband or wife James Douglas 6. (c) Age of husband or wife if alive Ur. 50 years

7. Birth date of deceased November 18, 1897
(Month) (Day) (Year)

8. AGE: Years 42 Months 9 Days 14 If less than one day hr. min.

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

10. Usual occupation Housewife

11. Industry or business _____

12. Name Doug Slaughter 13. Birthplace Arkansas
(City, town, or county) (State or foreign country)

14. Maiden name Parnellia Hudson 15. Birthplace Arkansas
(City, town, or county) (State or foreign country)

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

17. (a) burial (b) Date thereof 9/5/40
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Blue Ridge Lawn

18. (a) Signature of funeral director Hatkins Bros.
(b) Address 1729 Lydia

19. (a) Sept. 5, 1940 (b) M. M. Brown
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 9 day 2
year 40 hour 5 minute 20 P. M.

21. I hereby certify that I attended the deceased from 9-1-, 19 40 to 9-2-, 19 40
that I last saw her alive on 9-2-, 19 40
and that death occurred on the date and hour stated above.

Immediate cause of death
Hypertensive Type of Heart Disease.

Due to _____
Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____
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?

While at work? _____ (Specify type of place)
(e) Means of injury 1

23. Signature B. C. Brown (M. D. or other)
Address Gen. Hosp. #2 Date signed 9-4-40

Duration
PHYSICIAN
9582
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 *Isaac Jerome Manlove*

Licensed Embalmer No. *3994*

P. O. Address *1120 E 23rd 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.