

NOV 12 1940
599

Registration District No. _____

Primary Registration District No. **1002**

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 **9-17-40-10-1-40**
(Specify whether _____)
In this community **25 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. **2212 Montgall Ave**
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

3. (a) PRINT FULL NAME **Hawthorne "Jack" Wadkins**

3. (b) If veteran, name war **None** 3. (c) Social Security No. **495-01-3228**

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

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

7. Birth date of deceased **January 27, 1907**
(Month) (Day) (Year)

8. AGE: Years **33** Months **8** Days **4** If less than one day hr. _____ min.

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

10. Usual occupation **Laborer**

11. Industry or business _____

MOTHER FATHER
12. Name **Gilmore Wadkins**
13. Birthplace **Miss.**
(City, town, or county) (State or foreign country)
14. Maiden name **Orsa Kanion**
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 **10/5/40**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Highland Cemetery**

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

19. (a) **10-5-40** (b) **M. M. Browne**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **10** day **1**
year **40** hour **4** minute **25 P.M.**

21. I hereby certify that I attended the deceased from **9-17-** **1940**, to **10-1-** **1940**
that I last saw him alive on **10-1-** **1940**,
and that death occurred on the date and hour stated above.

Immediate cause of death
Generalized Peritonitis

Due to **Appendectomy (**

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 _____

23. Signature **H. O. Brown** (M. D. or other)
Address **Gen. Hosp. #2** Date signed **10-2-40**

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

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 Manlow

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.