

Registration District No. 399

Primary Registration District No.

Registrar's No.

1. PLACE OF DEATH:

(a) County Jackson
Kansas City
(b) City or town
(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 6 weeks
(Specify whether
In this community 25 yrs.
years, months or days)

3. (a) PRINT FULL NAME HENRY DELICK

3. (b) If veteran, name war no 3. (c) Social Security No. 709-10-9091

4. Sex Male 5. Color or race Wh. 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Virginia Delick 6. (c) Age of husband or wife if alive No Rec years
7. Birth date of deceased 5 20 1893
(Month) (Day) (Year)

8. AGE: Years 47 Months 4 Days 25 If less than one day hr. min.

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

10. Usual occupation Repair man

11. Industry or business B. & O. P. R.

12. Name George Living

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

14. Maiden name Anna

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

16. (a) Informant Mrs. Virginia Delick

(b) Address 1509 Penn K.C. Mo

17. (a) Burial (b) Date thereof 8-19-1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Int. Calvary Cem. K.C. Mo.

18. (a) Signature of funeral director J. P. Hall

(b) Address 6606 Ind. Ave. K.C. Mo

19. (a) 10-19-40 (b) M. M. Brown
(Date received local registrar) (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 limits, write "RURAL")
(d) Street No. 1509 Penn
(If rural, give location)
(e) If foreign born, how long in U. S. A.? No Record years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 15th
year 1940 hour 9 minute 55 A. M.

21. I hereby certify that I attended the deceased from 10-15-40, 19... to 10-15-40, 19...
that I last saw him alive on 10-15-40, 19...
and that death occurred on the date and hour stated above.

Immediate cause of death General paresis, Central nervous
Due to system lues
Due to 3H
Other conditions Acute glomerular nephritis
(Include pregnancy within 3 months of death)

General paresis, Central nervous

Due to system lues

Due to 3H

Due to

Other conditions Acute glomerular nephritis

(Include pregnancy within 3 months of death)

PHYSICIAN

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 Mary R. Shaw (M. D. or other)

med. Dir. R. C. Gen. Hospital, K. C. Mo. Date signed

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.....

Licensed Embalmer No.

P. O. Address.....

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.