

NOV 12 1940

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 10-22-40-10-24-40
(Specify whether
 In this community 9 Months
years, months or days)

3. (a) PRINT FULL NAME Jesse Beverly

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

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

7. Birth date of deceased 1 11 1940
(Month) (Day) (Year)

8. AGE: Years Months Days 0 9 -11- If less than one day
hr. min.

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

10. Usual occupation None

11. Industry or business

MOTHER FATHER { 12. Name Jesse Beverly
 { 13. Birthplace Kansas City Kansas
(City, town, or county) (State or foreign country)
 { 14. Maiden name Lillian Reeves
 { 15. Birthplace Kansas City Kansas
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Record Clerk
 (b) Address General Hospital #2

17. (a) Burial (b) Date thereof 10-26-40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Lincoln Cemetery

18. (a) Signature of funeral director H. B. Moore

(b) Address 1820 E. 19th Street

19. (a) 10-25-40 (b) M. M. Brown
(Date received local registrar) (Registrar's signature)

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. 815 Independence Ave.
(If rural, give location)
 (e) If foreign born, how long in U. S. A. years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 10 day 24
 year 40 hour 2 minute 40 P. M.

21. I hereby certify that I attended the deceased from 10-22-, 1940 to 10-24-, 1940
 that I last saw him alive on 10-24-, 1940
 and that death occurred on the date and hour stated above.

Immediate cause of death Tuberculosis (Pulmonary)

Due to
 Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
 Of operations
 Of autopsy

Duration
 PHYSICIAN
 Underline the cause to which death should be charged statistically

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 J. O. Quincy (M. D. or other)
 Address Gen. Hosp. #2 Date signed 10-25-40

WHITE PRINT—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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.....

A. B. Moore

Registered Apprentice No.....

working under my personal supervision.

Signed *A. B. Moore*

Licensed Embalmer No. *2410*

P. O. Address *1820 E. 18th 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.

Registration District No. 399

Primary Registration District No. 100

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 No. 2
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 10-22-40-10-24-40
(Specify whether
In this community 9 months
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson
(c) City or town Kansas City, Mo.
(If outside city or town limits, write "RURAL")
(d) Street No. 815 Independence Ave.
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME

Jesse Beverly, Jr.

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

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 Jan. 11 1940
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>9</u>	<u>13</u>	<u>11</u>	<u>br.</u> min.

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

10. Usual occupation none

11. Industry or business none

MOTHER FATHER {
12. Name Jesse Beverly
13. Birthplace Kansas City, Kansas
(City, town, or county) (State or foreign country)
14. Maiden name Lillian Reeves
15. Birthplace Kansas City, Kansas
(City, town, or county) (State or foreign country)

16. (a) Informant Record Clerk

(b) Address General Hospital No. 2

17. (a) Burial (b) Date thereof 10/26/40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Lincoln Cem

18. (a) Signature of funeral director B. Moore

(b) Address City

19. (a) 10/25/40 (b) M. M. Crowe
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 10 day 24
year 40 hour 2 minute 40 P. M.

21. I hereby certify that I attended the deceased from 10-22-40 to 10-24-40
that I last saw him alive on 10-24-40
and that death occurred on the date and hour stated above.

Immediate cause of death Primary Bronchopneumonia

Due to _____
Due to 10/24

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 P. Turner (M. D. or other) _____
Address General Hospital No. 2 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, fact should be so stated above.