

Registration District No. **399**

Primary Registration District No. **1002**

Registrar's No. **4287**

DEC 14 1940

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:
3232 Bellfountaine
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
In this community **57** (Specify whether years, months or days)

3. (a) PRINT FULL NAME **Dr. Darwin Delap**

3. (b) If veteran, name war **No. 10** 3. (c) Social Security No. **490**

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

6. (b) Name of husband or wife **Elizabeth Peirce Delap** 6. (c) Age of husband or wife if alive **61** years

7. Birth date of deceased **Oct. 12 1882**
(Month) (Day) (Year)

8. AGE: Years **58** Months **0** Days **27** If less than one day _____ hr. _____ min.

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

10. Usual occupation **Physician**

11. Industry or business _____

MOTHER FATHER { 12. Name **Silas C. Delap**
13. Birthplace **Gettsburg Pa.**
(City, town, or county) (State or foreign country)
14. Maiden name **Marion Kennedy**
15. Birthplace **New London Pa.**
(City, town, or county) (State or foreign country)

16. (a) Informant **Elizabeth Delap**
(b) Address **3232 Bellfountaine**

17. (a) **Cremation** (Burial, cremation, or removal) (b) Date thereof **Nov. 11-40**
(Month) (Day) (Year)
(c) Place: burial or cremation **Elmwood**

18. (a) Signature of funeral director **Eylar Funeral Home**

(b) Address **1800 Linwood K.C. Mo.**

19. (a) **11-11-40** (Date received local registrar) (b) **M. M. Brown** (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. **3232 Bellfountaine**
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **November** day **10th**
year **1940** hour **One** minute **30** A.M.

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

Immediate cause of death **Cerebral Hemorrhage** Duration **2 hrs.**

Due to **Chronic Hypertension** ?

Due to **Chronic Interstitial Nephritis** ?

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

Major findings: **131** Of operations _____

Of autopsy _____ 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 **A**

23. Signature **Ronald R. Collins** (M. D. or other) **P.D.**
Address **3523 Woodland** Date signed **11-10-40**

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

3523 Woodland

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 Chas Wilks

Licensed Embalmer No. 2644

P. O. Address 1800 Pinewood

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.