

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.

Registration District No. 399

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 town)
 (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 7 years
(Specify whether 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. 567 Charlotte
(If rural, give location)
 (e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 11 day 21
 year 40 hour 10 minute 25 P. M.

21. I hereby certify that I attended the deceased from
10-18-40, 1940, to 11-21, 1940
 that I last saw him alive on 11-21, 1940
 and that death occurred on the date and hour stated above.

Immediate cause of death
Septecemia-Lung abscess
following Lobar Pneumonia.

Duration

Due to _____

Due to _____

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

Major findings:
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) Means of injury _____

23. Signature: J. C. [Signature] (M. D. or other) _____
 Address: Gen. Hosp. #2 Date signed 11-25-40

3. (a) PRINT FULL NAME Jack Fessler

3. (b) If veteran SS446-09-9863 name war None
 3. (c) Social Security No. None

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

6. (b) Name of husband or wife Carrie Fessler
 6. (c) Age of husband or wife if alive 56 years

7. Birth date of deceased 6 6 1885
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>55</u>	<u>5</u>	<u>16</u>	_____ hr. _____ min.

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

10. Usual occupation Laborer

11. Industry or business _____

MOTHER FATHER
 12. Name Unknown
 13. Birthplace Unknown
(City, town, or county) (State or foreign country)
 14. Maiden name Unknown
 15. Birthplace Unknown
(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 11/30/40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Blue Ridge Lawn

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

19. (a) 11-29-40 (b) M. M. Cerone
(Date received local registrar) (Registrar's signature)

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 Meulove

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.