

Registration District No. 399

Primary Registration District No. 1002

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Kansas City

(c) Name of hospital or institution: Vacant Lot 45th & Mercier  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 3  
(Specify whether \_\_\_\_\_)

In this community unknown  
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. Vacant Lot 45th & Mercier  
(If rural, give location)

(e) If foreign born, how long in U. S. A.?  
\_\_\_\_\_ years.

3. (a) PRINT FULL NAME Unknown White Male

3. (b) If veteran, name war don't know

3. (c) Social Security No. ✓

4. Sex Male

5. Color or race White

6. (a) Single, widowed, married, divorced unk

6. (b) Name of husband or wife Don't know

6. (c) Age of husband or wife if alive unk years

7. Birth date of deceased unknown  
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>about 65</u>			hr. min.

9. Birthplace Don't know 9  
(City, town, or county) (State or foreign country)

10. Usual occupation Labor 1

11. Industry or business \_\_\_\_\_

MOTHER FATHER

12. Name Don't know 1

13. Birthplace Don't know 1  
(City, town, or county) (State or foreign country)

14. Maiden name Don't know

15. Birthplace Don't know  
(City, town, or county) (State or foreign country)

16. (a) Informant Coroner Office

(b) Address Kan City, Mo.

17. (a) NW 30 40 (b) Date thereof \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Green Lawn

18. (a) Signature of funeral director Steintacher M.D.

(b) Address 149 W. Mill Creek Pky

19. (a) 11/30/40 (b) M. B. Brown  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 22  
year 1940 hour 2 minute 30 M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_; that ~~he~~ she was alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_

Due to Chronic myocarditis

Due to 93C

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Of operations \_\_\_\_\_

Of autopsy Inspection

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) \_\_\_\_\_

23. Signature Arthur B. Brown (M. D. or other) \_\_\_\_\_

Address H. C. Brown 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.....

*H. Bergman*

Licensed Embalmer No. *2041*

P. O. Address. *700 2nd*

**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.**