

FEB 18 1941
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: General Hospital #2.
(d) Length of stay: In hospital or institution 12-28-40-1-2-41
In this community 1 1/2 years.

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo. (b) County Jackson
(c) City or town Kansas City
(d) Street No. 732 1/2 Campbell St.
(e) If foreign born, how long in U. S. A. ? _____ years.

3. (a) PRINT FULL NAME Richard Beck.

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

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

6. (b) Name of husband or wife Unknown 6. (c) Age of husband or wife if alive 25 years

7. Birth date of deceased 4 25 1862
(Month) (Day) (Year)

8. AGE: Years 79 Months 8 Days 27 If less than one day hr. _____ min. _____

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

10. Usual occupation Unemployed.

11. Industry or business _____

MOTHER FATHER { 12. Name Unknown
13. Birthplace Unknown
14. Maiden name Unknown
15. Birthplace Unknown

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

17. (a) Burial (b) Date thereof 1-3-41
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Joseph's

18. (a) Signature of funeral director W. H. Appleton
(b) Address 15 S. Main

19. (a) Jan 3, 1941 (b) W. H. Crowe
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 1 day 2
year 41 hour 3 minute 30 P. M.

21. I hereby certify that I attended the deceased from 12-28-40, 19____, to 1-2-, 1941;
that I last saw him alive on 1-2-, 1941;
and that death occurred on the date and hour stated above.

Immediate cause of death Acute Congestive Heart Failure.

Due to _____
Due to _____

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

PHYSICIAN
Major findings: _____
Of operations _____
Of autopsy _____
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)
(or) means of injury _____

23. Signature [Signature] (M. D. or other) _____
Address _____ Date signed _____

WRITE PLAINLY—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.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed *C. H. West*.....

Licensed Embalmer No. *2710*.....

P. O. Address *15. 0700*.....

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.