

No. 2
4-13-40
5-17-39
I X23139

MAR 14 1941

Registration District No. 399

Primary Registration District No. 1002

48
3
8
WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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: K.C. General Hospital No. 1 0
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 days
(Specify whether In this community _____ years, months or days)

In this community 30 years

3. (a) PRINT FULL NAME JACK SEARS

3. (b) If veteran, name war _____

3. (c) Social Security No. No

4. Sex Male 5. Color or race White

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

6. (b) Name of husband or wife _____

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

7. Birth date of deceased July 8th 1863
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>77</u>	<u>6</u>	<u>24</u>	hr. min.

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

10. Usual occupation None

11. Industry or business _____

MOTHER FATHER {

12. Name Joseph Sears

13. Birthplace dont know 9
(City, town, or county) (State or foreign country)

14. Maiden name C. Kerns

15. Birthplace Greenlawn, dont know 9
(City, town, or county) (State or foreign country)

16. (a) Informant Record clerk

(b) Address K.C. Gen. Hospital K.C. Mo.

17. (a) Burial (b) Date thereof 2-5-1941
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Greenlawn Cem.

18. (a) Signature of funeral director W. A. Lohmeyer City Mo.
(Specify type of place)

(b) Address K.C. Gen. Hospital

19. (a) 2/6/41 (b) M. M. Crow
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED: 48

(a) State Missouri (b) County Jackson

(c) City or town Kansas City
(If outside city or town limits, write "RURAL")

(d) Street No. 349 Maple
(If rural, give location)

(e) If foreign born, how long in U. S. A.? 0 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 1st
year 1941 hour 2 minute 40 P. M.

21. I hereby certify that I attended the deceased from 1-30-41, 19____, to 2-1-41, 19____;
that I last saw him alive on 2-1-1941, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic arteriosclerotic vascular nephritis; hypertrophied heart
Duration

Due to _____

Due to _____

Other conditions Secondary Cirrhosis of liver
(Include pregnancy within 3 months of death)

PHYSICIAN _____

Major findings: _____

Of operations _____

Of autopsy See above

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? _____

(e) Means of injury 0

23. Signature Dwight R. Johnson (M. D. or other) _____

Address Med. Dir. K.C. Gen. Hospital Date signed _____

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: *Wm A Johnson*

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.