

Registration District No. **399**

Primary 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 township)
(c) Name of hospital or institution: **K.C. General Hospital**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **1 day** (Specify whether years, months or days)
In this community **37 years**

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Jackson**
(c) City or town **Kansas City**
(If outside city or town limits, write "RURAL")
(d) Street No. **514 Main St.**
(If rural, give location)
(e) Citizen of foreign country? **0** (Yes or No)
If yes, name country

3. (c) PRINT FULL NAME **Fred Scidmore**

3. (b) If veteran, name war **-** 3. (c) Social Security No. **unk**

4. Sex **M.** 5. Color or race **W.** 6. (a) Single, widowed, married, divorced **Widower**

6. (b) Name of husband or wife **unknown** 6. (c) Age of husband or wife if alive **-** years

7. Birth date of deceased **Dec. 12th 1888**
(Month) (Day) (Year)

8. AGE: Years **72** Months **1** Days **11** If less than one day hr. min.

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

10. Usual occupation **Brick layer**

11. Industry or business

12. Name **John Scidmore**

13. Birthplace **New York**
(City, town, or county) (State or foreign country)

14. Maiden name **Mary Taylor**

15. Birthplace **Virginia**
(City, town, or county) (State or foreign country)

16. (a) Informant **Record clerk**

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

17. (a) **Anatomical** (b) Date thereof **2 15 41**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **K.C. College of Osteo.**

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

(b) Address **2332 Monitor Pl. K.C. Mo.**

19. (a) **2/16/1941** (b) **M. M. Crowe**
(Date received local registrar) (Registrar's signature)

(Licensed Embalmer's Statement on Reverse Side)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Jan.** day **23rd**
year **1941** hour **4** minute **25 P.** M.

21. I hereby certify that I attended the deceased from **1-22-41** to **1-23-41**
that I last saw him alive on **1-23-41**
and that death occurred on the date and hour stated above.

Immediate cause of death **Cerebral hemorrhage**

Due to **8:30-4:30**
Due to

Other conditions **Bronchopneumonia**
(Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy **None**

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) (c) Means of injury **0**

23. Signature **Dr. R. L. Johnson** (M. D. or other)
Address **Med. Dir. K.C. Gen. Hosp.** Date signed

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

18
3
8
0

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.....

Blaine E. Weiland

Licensed Embalmer No. *4075*

P. O. Address *2332 Monitor 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, fact should be so stated above.