

APR 15 1941

Registration District No. 277

Primary Registration District No. 1002

Registrar's No. 1190

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 Mo. & 11 days
(Specify whether
In this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 48
(c) City or town Kansas City 3
(If outside city or town limits, write "RURAL") 8
(d) Street No. 3320 Prospect
(If rural, give location)
(e) Citizen of foreign country? 0 (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 14th
year 1941 hour 6 minute 30 P. M.

21. I hereby certify that I attended the deceased from 2-3-41 1941 to 3-14-41 1941;
that I last saw him alive on 3-14-41 1941;
and that death occurred on the date and hour stated above.

Immediate cause of death auricular fibrillation Duration _____

Due to 450

Due to _____

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

Major findings: _____
Of operations _____

Of autopsy None _____
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)
(e) Means of injury _____

23. Signature Wm. R. Horn (M.D. or other) _____
Address Med. Dir. K.C. Gen. Hospital Date signed 3-27-41

3. (a) PRINT FULL NAME Earl Trent

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

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

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

7. Birth date of deceased June 1st 1873
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
67 9 13 hr. min.

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

10. Usual occupation Laborer

11. Industry or business _____

12. Name Jacob Trent

13. Birthplace Florida (City, town, or county) (State or foreign country)

14. Maiden name Ella Wood

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

16. (a) Informant Record Clerk

(b) Address K.C. General Hospital

17. (a) Burial (b) Date thereof 3-24-41
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Leeds Municipal Cem.
W.A. Lohmeyer

18. (a) Signature of funeral director _____

(b) Address City mortician

19. (a) Arch 23/1941 (b) M. M. Crowe
(Date received local registrar) (Registrar's signature)

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

18398

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.....

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.