

FILED SEP 12 1941
Registration District No. **377**

Primary Registration District No. **1002**

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:
General Hospital #2
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **8-1-41-8-15-41**
(Specify whether years, months or days) **17 years** **D**

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Jackson** **049**

(c) City or town **Kansas City** **3**
(If outside city or town limits, write "RURAL") **D**

(d) Street No. **2215 E. 21st**
(If rural, give location)

(e) Citizen of foreign country? **No** (Yes or No) **D**
If yes, name country

3. (a) PRINT FULL NAME **FRED GIBBS**

3. (b) If veteran, name war **—**

3. (c) Social Security No. **—**

4. Sex **Male** **2** 5. Color or race **Negro**

6. (a) Single, widowed, married, divorced **Wid.**

6. (b) Name of husband or wife **Unknown**

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

7. Birth date of deceased **August 3 1889**
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	52		12	hr. min.

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

10. Usual occupation **Unemployed**

11. Industry or business

12. Name **Deceased**

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

14. Maiden name **Deceased**

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

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

(b) Address **General Hospital #2**

17. (a) **Burial** (b) Date thereof **8-18-1941**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Local Cemetery**

18. (a) Signature of funeral director **J. M. Crow**

(b) Address **891709 7. 13th St. C. Mo.**

19. (a) **8/18/41** (b) **M. M. Crow**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **August** day **15**
year **1941** hour **8** minute **15 a.m.**

21. I hereby certify that I attended the deceased from **8-1-41** 19 to **8-15-41** 19;
that I last saw him alive on **August 15** 19 **41**
and that death occurred on the date and hour stated above.

Immediate cause of death **Lobar Pneumonia**

Due to **104**

Due to **104**

Other conditions (Include pregnancy within 3 months of death)

Major findings: **Leucopenia**

Of operations

Of autopsy

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) (b) Means of injury

23. Signature **J. M. Crow** (M.D. or other) **D**
Address **General Hospital #2** Date signed **8/16/41**

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 Fannie T. Meep

Licensed Embalmer No. 3818

P. O. Address 1708 E. 18th

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.