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FILLED NOV 13 1941
377

Registration District No. _____

Primary Registration District No. 1002

1. PLACE OF DEATH: Jackson
 (a) County Kansas City
 (b) City or town _____
 (c) Name of hospital or institution: K.C. General Hospital No. 1
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 2 days
 In this community 15 yrs (Specify whether years, months or days) 0

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County Jackson **048**
 (c) City or town Kansas City
 (d) Street No. 710 West 33rd St.
 (e) If foreign born, how long in U. S. A? 0 years.

3. (a) PRINT FULL NAME EDITH GARRISON

MEDICAL CERTIFICATION
Oct. 13th

3. (b) If veteran, name war No 3. (c) Social Security No. 486-03-4760

20. DATE OF DEATH: Month _____ day _____
year 1941 hour 10:00 A.M. M.

4. Sex F. 5. Color or race W. 6. (a) Single, widowed, married, divorced Wid - I

21. I hereby certify that I attended the deceased from 10-11-41, 19____, to 10-13-41, 19____;

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

that I last saw h. er alive on 10-13-41, 19____; and that death occurred on the date and hour stated above.

7. Birth date of deceased: _____ (Month) _____ (Day) _____ (Year)

Immediate cause of death MALIGNANT HYPERTENSION

8. AGE:	Years	Months	Days	If less than one day
	<u>40</u>	<u>10</u>	<u>1</u>	____ hr. ____ min.

Due to _____ 102

9. Birthplace Galena, Kansas (City, town, or county) _____ (State or foreign country)

Due to _____

10. Usual occupation Clerk

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

11. Industry or business Office

Major findings: _____

12. Name Robert A. Cappel

Of operations _____

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

Of autopsy None

14. Maiden name Margaret Cappel

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

16. (a) Informant Miss Marie Hart

(b) Address 710 W 33 St

17. (a) Burial (b) Date thereof 10-15-41 (Month) (Day) (Year)

(c) Place: burial or cremation Green Lawn

18. (a) Signature of funeral director Sheil Funeral Home

(b) Address Kansas City, Mo

19. (a) 10/14/41 (Date received local registrar) (b) M. M. Mcrowe (Registrar's signature)

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? _____

(Specify type of place) _____

While at work? _____ (Specify type of place) _____

23. Signature Mary R. Thoon (M. D. or other) ()

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

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

048
202

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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 the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.