

No. 2
4-13-40
5-17-39
P1 X23159

Registration District No. **397** Primary Registration District No. **1002**

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

1. PLACE OF DEATH: Jackson
(a) County: Kansas City
(b) City or town: Kansas City
(c) Name of hospital or institution: K.C. General Hospital No. 1
(d) Length of stay: In hospital or institution: Outpatient K.C. Gen. Hosp. 20 yrs.
In this community: 20 yrs.

2. USUAL RESIDENCE OF DECEASED: 048
(a) State: Missouri (b) County: Jackson 3
(c) City or town: Kansas City
(d) Street No.: 1020 Locust St.
(e) If foreign born, how long in U. S. A.? 10 years.

3. (a) PRINT FULL NAME: John W. Edwards
(b) If veteran, name war: no
(c) Social Security No.: none

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month: Dec. day: 10th
year: 1941 hour: 10 minute: 25 P.M.

4. Sex: male 0
5. Color or race: White
6. (a) Single, widowed, married, divorced: Wid 1
6. (b) Name of husband or wife: Nettie Edwards
6. (c) Age of husband or wife if alive: _____ years
7. Birth date of deceased: August 8, 1966
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from July 1938, 19, to Dec. 10th 1941, 19, that I last saw him alive on Dec. 4th, 1941, and that death occurred on the date and hour stated above.

8. AGE: Years: 75 Months: 4 Days: 2
If less than one day: _____ hr. _____ min.

Immediate cause of death: Hypertensive heart disease with congestive failure
Duration: _____

9. Birthplace: Indiana
(City, town, or county) (State or foreign country)
10. Usual occupation: Grain Buyer

Other conditions: _____
Major findings: Of operations: _____
Of autopsy: _____
PHYSICIAN: _____
Underline the cause to which death should be charged statistically.

MOTHER FATHER {
11. Industry or business: _____
12. Name: Soloman Edwards
13. Birthplace: Indiana
14. Maiden name: Martina Jane Carmichael
15. Birthplace: Indiana

16. (a) Informant: Nettie Walger
(b) Address: 1005 Locust

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? _____
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

17. (a) Removal: _____ (b) Date thereof: Dec. 12, 1941
(c) Place: burial or cremation: Hopkins Missouri

18. (a) Signature of funeral director: Mrs C.L. Forster
(b) Address: 918 Brooklyn
19. (a) Date received local registrar: Dec 12, 41 (b) Registrar's signature: M. M. Crowe

23. Signature: _____ (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 *me*

....., Registered Apprentice No.....
working under my personal supervision.

Signed

L. H. Wise

Licensed Embalmer No.

2570

P. O. Address

K. C. Mo

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.