

FILED OCT 24 1942

Registration District No. _____

Primary Registration District No. 1002

Registrar's No. 3828

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 No. 10
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 1/2 months
In this community 25 yrs
years, months or days

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. 2200 1/2 East 15th St.
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country.

3. (a) PRINT FULL NAME Charles C. Moad

3. (b) If veteran, name war none
3. (c) Social Security No. none

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 Apr 9 1904
(Month) (Day) (Year)

8. AGE: Years 58 Months 6 Days 8 If less than one day hr. min.

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

10. Usual occupation Restaurant Operator

11. Industry or business Self

12. Name Martel Moad

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

14. Maiden name Martha Beck

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

16. (a) Informant Stewart Moad

(b) Address North Kansas City Mo

17. (a) Burial (b) Date thereof Sep 17 42
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Greenlawn

18. (a) Signature of funeral director Sheil General

(b) Address Kansas City Mo

19. (a) 10-17-42 (b) M. M. Browne
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 15th
year 1942 hour 9 minute 45 P. M.

21. I hereby certify that I attended the deceased from 8-30-42
19 to 10-15-42 19
that I last saw him alive on 10-15-42 19
and that death occurred on the date and hour stated above.

Immediate cause of death
Rheumatic Heart Disease
Due to 95 B
Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy
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?

(Specify type of place) While at work Means of injury
23. Signature Drury R. Johnson (M.D. or other)
Address Bir. K. General Hospital Date signed

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

48
33
8

48
33
8

MOTHER FATHER

48

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.....

J.P. Shurl
.....
Licensed Embalmer No. 2635 -

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.