

FILED DEC 7 1942
7/9

Registration District No.

Primary Registration District No. 1002

Registrar's No. 4311

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Kansas City
(c) Name of hospital or institution O K.C. General Hospital, No. 1
(d) Length of stay: In hospital or institution 1 day
In this community 20 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson
(c) City or town Kansas City
(d) Street No. 3830 Forest
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME James Townsend

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

4. Sex Male
5. Color or Race White
6. (a) Single, widowed, married, divorced, or widowed
6. (b) Name of husband or wife Wade J. Townsend
6. (c) Age of husband or wife if alive 73 years
7. Birth date of deceased March 18-1867

8. AGE: Years 75 Months 7 Days 29
If less than one day hr. min.

9. Birthplace Pa 1

10. Usual occupation Retail (Master) (Yard)

11. Industry or business Central Coal & Co

12. Name Robert Townsend

13. Birthplace Pa 1

14. Maiden name Elizabeth Durrett

15. Birthplace Miss 1

16. (a) Informant James A. Townsend Jr

(b) Address 3014 Harrison

17. (a) Burial (b) Date thereof Nov 19-1942

(c) Place: burial or cremation Mt Washington

18. (a) Signature of funeral director Wm. C. Foster

(b) Address 918 Brooklyn

19. (a) 11-19-42 (b) W. W. Crowe

(Data received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 17th
year 1942 hour 12 minute 50 A.M.

21. I hereby certify that I attended the deceased from 11-16-42 to 11-17-42
that I last saw him alive on 11-17-42
and that death occurred on the date and hour stated above.

Chronic cardiac disease (type undetermined) with acute cardiac failure

Due to 95c
Due to

Other conditions Prostatism with acute retention of urine

Major findings: Of operations
Of autopsy None

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?

While at work? (Specify type of place)
Signature Wm. R. Thor (M. D. or other)
Address Med. Dir. K.C. Gen. Hospital Date signed

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

MOTHER FATHER

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 Genzil E. Browning
Licensed Embalmer No. 2724
P. O. Address N. E. 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.