

FILED DEC 28 1942 49

Registration District No. _____

Primary Registration District No. 1002

Registrar's No. 4681

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Kansas City, Missouri
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Kansas City SBC Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 28 Day
In this community 39 years (Specify whether 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. 1220 Olive
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME MARTIN, JACK HOWARD

3. (b) If veteran, name war no
3. (c) Social Security No. 494-12-3155

4. Sex M 5. Color or Race W
6. (a) Single, widowed, married, divorced M

6. (b) Name of husband or wife Mrs. Edna Fay Martin
6. (c) Age of husband or wife if alive 39 years

7. Birth date of deceased 12 (Month) 10 (Day) 1903 (Year)

8. AGE: Years Months Days If less than one day
39 0 4 2 hr. 30 min.

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

10. Usual occupation Auto mechanic

11. Industry or business _____

MOTHER FATHER
12. Name Joseph Martin
13. Birthplace Kansas City, Mo.
(City, town, or county) (State or foreign country)
14. Maiden name Bence, Bence
15. Birthplace Kansas City, Mo.
(City, town, or county) (State or foreign country)

16. (a) Informant Funeral
(b) Address Kaiser Hospital

17. (a) Burial (b) Date thereof Dec-16-1942
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Admission

18. (a) Signature of funeral director Mrs. C. R. Foster

(b) Address 918 Brooklyn

19. (a) 12-15-42 (b) M. M. Brown
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month December day 14
year 1942 hour 2:30 minute 45 M.

21. I hereby certify that I attended the deceased from Nov 18
1942 to Dec 14 19 42
that I last saw him alive on Dec 14 19 42
and that death occurred on the date and hour stated above.

Immediate cause of death Advanced Pulmonary Tuberculosis

Due to _____

Due to _____

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

Major findings: Of operations _____
Of autopsy _____

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) (Means of injury)

23. Signature C. C. Brown, M.D. (M. D. or other)
Address K. C. Hospital Date signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

MC

561

(Licensed Embalmer's Statement on Reverse Side)

K. C. Brown

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 *Peniel C. Browning*
Licensed Embalmer No. *2724*
P. O. Address *J. C. No*

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.