

FILED MAR 5 1943
749

Registration District No. _____

Primary Registration District No. _____

1002

781

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. 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 Mo. & 10 days
(Specify whether
In this community 42 years.
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. Federick Hotel 312 E. 9th.
(If rural, give location)
(e) Citizen of foreign country? no. (Yes or No)
If yes, name country X

3. (a) PRINT FULL NAME Nathan Corning

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 Widowed

6. (b) Name of husband or wife Unknown 6. (c) Age of husband or wife if alive X years

7. Birth date of deceased October 1 1857
(Month) (Day) (Year)

8. AGE: Years 85⁰² Months 4 Days 13 If less than one day
hr. min.

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

10. Usual occupation at home,

11. Industry or business X

12. Name H. Corning,

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

14. Maiden name Mansfield,

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

16. (a) Informant Mrs. Gladys Hansen,

(b) Address Macon, Mo.

17. (a) removal (b) Date thereof 2-14-43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Macon, Missouri

18. (a) Signature of funeral director Stine & McClure,

(b) Address 3235 Gillham Plaza, K. C., Mo.

19. (a) 2-15-43 (b) M. M. Corning
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 14th
year 1943 hour 4 minute 30 P. M.

21. I hereby certify that I attended the deceased from 1-4-43, 19____, to 2-14-43, 19____;
that I last saw him alive on 2-14-43, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma of lung-not confirmed by autopsy

Due to 472

Other conditions (include pregnancy within 3 months of death)

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? _____ (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) (c) Means of injury _____
23. Signature Dwight R. Shon (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

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. 1413

P. O. Address. N. P. 1220

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.