

FILED FEB 25 1943
149

Registration District No.

Primary Registration District No. 1002

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 13 days
In this community 41 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. 548 Main
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country 0

3. (a) PRINT James Wood
FULL NAME

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

4. Sex M. 5. Color or race W. 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 July 21st 1872
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
70 6 3 hr. min.

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

10. Usual occupation None

11. Industry or business -----

12. Name William Wood

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

14. Maiden name Amanda Hays

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

16. (a) Informant Record clerk
K.C. Gen. Hospital

(b) Address -----
17. (a) Burial (b) Date thereof 2-5-43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Field

18. (a) Signature of funeral director Wm. J. Johnson

(b) Address W. J. Johnson

19. (a) 2-5-43 (b) M. M. Brown
(Date received from registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 24th
year 1943 hour 5 minute 20 A. M. P. M.

21. I hereby certify that I attended the deceased from 1-11-43 to 1-24-43
that I last saw him alive on 1-24-43
and that death occurred on the date and hour stated above.

Immediate cause of death
Hypertensive cardio vascular disease with hypostatic broncho pneumonia

Due to HTN
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) -----
(e) Means of injury -----
23. Signature Dr. R. Johnson (M. D. or other) -----
Address Med Dir. K.C. General 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.....

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.