

FILED OCT 13 1943 14

Registration District No. _____

Primary Registration District No. 1002

Registrar's No. 4136

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: General Hospital No. 2
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 4 hours
(Specify whether years, months or days)

In this community 52 years
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 48

(c) City or town Kansas City 3
(If outside city or town limits, write "RURAL")

(d) Street No. 2535 Highland 8
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME FRANK WATKINS

3. (b) If veteran, name war None

3. (c) Social Security No. 493-12-8258

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 23
year 1943 hour 7:30 minute 15 A.M.

21. I hereby certify that I attended the deceased from 9-22
1943 to 9-23 1943
that I last saw him im alive on Sept. 23 1943
and that death occurred on the date and hour stated above.

4. Sex Male 5. Color or race Negro 6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife Alice Watkins 6. (c) Age of husband or wife if alive 50 years

7. Birth date of deceased June 28, 1891
(Month) (Day) (Year)

Immediate cause of death Cerebral Vascular Accident Duration _____

8. AGE:	Years	Months	Days	If less than one day
	<u>52</u>	<u>2</u>	<u>25</u>	_____hr. _____min.

Due to Hypertensive Heart Disease

9. Birthplace Kansas City, Missouri 0
(City, town, or county) (State or foreign country)

Due to _____

10. Usual occupation Laborer

Other conditions 93d
(Include pregnancy within 3 months of death)

11. Industry or business North American Plant

12. Name Peter Watkins

13. Birthplace Jefferson City, Mo. 0
(City, town, or county) (State or foreign country)

14. Maiden name Sarah Bruce

15. Birthplace Salem, North Carolina /
(City, town, or county) (State or foreign country)

16. (a) Informant Record Clerk

(b) Address General Hospital No. 2

17. (a) burial (b) Date thereof 9/27/43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Highland Cemetery

18. (a) Signature of funeral director Hollans Bros.

(b) Address 1729 Lydia, K. C., Mo.

19. (a) 9-29-43 (b) J. E. Brown, Dep
(Date received local registrar) (Registrar's signature)

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? _____

While at work? _____
(Specify type of place) (Means of injury)

23. Signature J. E. Brown (M. D. or other) MD
Address General Hosp. No. 2 Date signed 9-24-43

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

MOTHER FATHER

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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. Jerome Mandon

Licensed Embalmer No. *3994*

P. O. Address *2503 Highland*

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.