

DEPARTMENT OF COMMERCE
 BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED NOV 1 1943

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 4379

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 10 days
(Specify whether
 In this community No Record
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. 2501 W. 9 St.
(If rural, give location)
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME Lewis Day

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 Single

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

7. Birth date of deceased No Record as to Date
(Month) (Day) (Year)

8. AGE: Years 72 Months - Days - If less than one day hr. _____ min. _____

9. Birthplace No Record 9
(City, town, or county) (State or foreign country)

10. Usual occupation None. (Blind man)

11. Industry or business _____

12. Name Lewis Day 9

13. Birthplace No Record 9
(City, town, or county) (State or foreign country)

14. Maiden name _____

15. Birthplace No Record 9
(City, town, or county) (State or foreign country)

16. (a) Informant ally Duffich - for

(b) Address Public Administration

17. (a) Burial (b) Date thereof Oct 15-43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Almwood Cem

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

(b) Address 915 Brooklyn

19. (a) 10-15-43 (b) J C Brown
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 13th
 year 1943 hour 11 minute 15 P.M.

21. I hereby certify that I attended the deceased from Oct. 3rd 1943 to Oct. 13th 1943
 that I last saw him alive on Oct. 13th 1943
 and that death occurred on the date and hour stated above.

Immediate cause of death Cardiac Insufficiency

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 Wm R. Thorn (M. D. or other) _____

Address Med. Div. Gen Hosp. Date signed 10-14-43

PHYSICIAN
 Underline the cause to which death should be charged statistically.

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

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 R. W. Runnels

Licensed Embalmer No. 3860

P. O. Address Kansas City 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.