

FILED NOV 14 1944
Registration District No. 147

Primary Registration District No. 1002

Registrar's No. 4452

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

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) 0
(d) Length of stay: In hospital or institution 2 days (Specify whether
In this community 35 years 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. 1921 1/2 Cleveland 0
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME William Perry
3. (b) If veteran, name war no. 3. (c) Social Security No. 487-16-7748

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Nov. day 2
year 1944 hour 2 minute 45 A.M.

4. Sex male 5. Color or race white
6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife Rosa Belle Perry 6. (c) Age of husband or wife if alive 56 years
7. Birth date of deceased Dec. 19th. 1873
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Oct. 31 1944 to Nov. 2 1944
that I last saw him alive on Nov. 2 1944
and that death occurred on the date and hour stated above.

8. AGE: Years 70 Months 10 Days 13
If less than one day hr. min.

Immediate cause of death Carcinoma of stomach Duration _____

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

Due to _____
Due to 46 _____

10. Usual occupation laborer

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

11. Industry or business _____
MOTHER FATHER { 12. Name William H. Perry
13. Birthplace Ky. (City, town, or county) (State or foreign country)
14. Maiden name Unknown
15. Birthplace Unknown (City, town, or county) (State or foreign country)

Major findings: Of operations _____
Of autopsy See above PHYSICIAN _____
Underline the cause to which death should be charged statistically.

16. (a) Informant Mrs. Rosa Belle Perry
(b) Address 1921 1/2 Cleveland Ave. K.C. Mo.
17. (a) burial (Burial, cremation, or removal) (b) Date thereof 11/6/44 (Month) (Day) (Year)
(c) Place: burial or cremation Forest Hill Cem.

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? _____

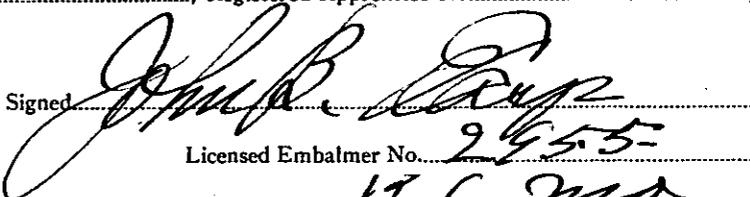
18. (a) Signature of funeral director Earp Funeral Home
(b) Address 4139 E. 15th. St. K.C. Mo.
19. (a) 11-6-44 (Date received local registrar) (b) I. E. Brown (43) (Registrar's signature)

(Specify type of place) While at work _____ (e) Means of injury _____
23. Signature A. E. Upsher (M. D. or other) MD
Address Med. Dir. Gen'l Hosp. Date signed 11-2-44

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. 2955-
P. O. Address 17 C. [unclear]

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.