

FILED DEC 22 1944  
Registration District No. **117**

Primary Registration District No. **1002**

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:  
**Gen. Hosp. #2**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution **10-19-44-11-9-44**  
(Specify whether years, months or days) **50 years**

3. (a) PRINT FULL NAME **CLARENCE TEASDALE**

3. (b) If veteran, name war **no** 3. (c) Social Security No. **none**

4. Sex **Male** 5. Color or race **Negro**  
6. (a) Single, widowed, married, divorced **Widower**  
6. (b) Name of husband or wife **unknown**  
6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased **March 10 1874**  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
**70 7 29** hr. min.

9. Birthplace **Higginsville Mo.**  
(City, town, or county) (State or foreign country)

10. Usual occupation **Unemployed**

11. Industry or business \_\_\_\_\_

MOTHER FATHER

12. Name **Henry Teasdale**  
13. Birthplace **Mo.**  
(City, town, or county) (State or foreign country)  
14. Maiden name **unknown**  
15. Birthplace **unknown**  
(City, town, or county) (State or foreign country)

16. (a) Informant **Record Clerk**  
(b) Address **Gen. Hosp. #2**

17. (c) **Burial** (b) Date thereof **12-13-44**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **burial**  
18. (a) Signature of funeral director **Wm A. Brown**  
(b) Address **City mortician**

19. (a) **12-12-44** (b) **T. E. Brown (V3)**  
(Date received local registrar) (Registrar's signature)

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. **18th & Harrison Apt. 24**  
(If rural, give location)  
(e) Citizen of foreign country? **No** (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Nov.** day **9**  
year **1944** hour **10:00** minute **P.** M.  
21. I hereby certify that I attended the deceased from **Oct. 19**, 19 **44**, to **Nov. 9**, 19 **44**  
that I last saw him alive on **Nov. 9**, 19 **44**,  
and that death occurred on the date and hour stated above.

Immediate cause of death **Septicemia**  
Due to **Abscess of jaw**

Due to **Carious teeth**  
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) (e) Means of injury \_\_\_\_\_  
23. Signature **A. C. Thomas** (D. or other)  
Address **Gen. Hosp. #2 600 E. 22nd** Date signed **11-13-44**

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

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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.....

..... 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.**