

FILED JAN 26 1945

State File No. _____
 Registrar's No. 5426

Registration District No. 149

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 3 days
(Specify whether
 In this community unknown
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. Ashland Hotel
(If rural, give location)
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME Albert Newman
 3. (b) If veteran, name war no
 3. (c) Social Security No. none

4. Sex male 5. Color of race white
 (a) Single, widowed, married, divorced unk.
 6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased _____
(Month) (Day) (Year)

8. AGE: Years 73 Months _____ Days _____ If less than one day _____ hr. _____ min.

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

10. Usual occupation none

11. Industry or business _____

12. Name unknown

13. Birthplace unknown
(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 Rec'd Clerk

(b) Address K.C. Gen. Hosp.

17. (a) K.C. Gen. Hosp. (b) Date thereof 1-3-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation K.C. Ambulatory

18. (a) Signature of funeral director Wm. A. Brown

(b) Address City

19. (a) 12-31-44 (b) L. B. Brown
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month Dec. day 29th
 year 1944 hour 4 minute 41 P. M.

21. I hereby certify that I attended the deceased from 12-26-44 19____ to 12-29-44 19____
 that I last saw h. im. alive on 12-29-44 19____
 and that death occurred on the date and hour stated above.

Immediate cause of death CORONARY OCCLUSION WITH MYOCARDIAL INFARCTION

Due to _____

Due to _____

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

Major findings: Of operations _____

Of autopsy None

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? _____

23. Signature C. E. Upsher
(Specify type of place) (c) Mode of injury

Address Med. Dir. K.C. Gen. Hospital K.C. Mo.
(M. D. occupation) Date signed 12-30-44

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

MOTHER FATHER

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.