

FILED MAR 24 1945 / 49

Registration District No.

Primary Registration District No.

1002

Registrar's No.

1029

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

1. PLACE OF DEATH:

(a) County Jackson
 (b) City or town Kansas City
 (c) Name of hospital or institution: Research
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 2 weeks
 In this community 50 yrs
 (Specify whether years, months or days)

3. (a) PRINT FULL NAME ALBERT JAMES BAGLEY

3. (b) If veteran, name war no
 3. (c) Social Security No. 707-10-0191

4. Sex M 5. Color or race W
 6. (a) Single, widowed, married, divorced widowed
 6. (b) Name of husband or wife Eva
 6. (c) Age of husband or wife if alive 22 years
 7. Birth date of deceased 9 2 6 1868
 (Month) (Day) (Year)

8. AGE: Years 76 Months 05 Days 27
 If less than one day hr. min.

9. Birthplace Le Grasse W. Va.
 (City, town, or county) (State or foreign country)

10. Usual occupation R. P. Conductor

11. Industry or business

MOTHER FATHER
 12. Name no record
 13. Birthplace ✓ - 9
 (City, town, or county) (State or foreign country)
 14. Maiden name no record
 15. Birthplace ✓ - 9
 (City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Clara Nicholson

(b) Address 6305 Indey Ave

17. (a) Burial (b) Date thereof 3.5-45
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Washington

18. (a) Signature of funeral director Kansas City

(b) Address 3-4-45 (b) T. E. Brown
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Jackson
 (c) City or town Kansas City 49
 (If outside city or town limits, write "RURAL")
 (d) Street No. 6305 Indey Ave
 (If rural, give location)
 (e) Citizen of foreign country? no (Yes or No)
 If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 3 year 1945 hour 11 minute 45 M.
 21. I hereby certify that I attended the deceased from February 15, 1945, to March 3, 1945, that I last saw him alive on March 3, 1945, and that death occurred on the date and hour stated above.

Immediate cause of death Myocardial exhaustion (chronic)
 Due to Carcinoma Prostate, with anemia
 Due to 518

Other conditions (Include pregnancy within 3 months of death)
 Major findings: Of operations none
 Of autopsy Prostatic Carcinoma (hyper trophy)

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? (Specify type of place) (e) Means of injury

23. Signature [Signature] (M. D. or other)
 Address 1019 Pop Blvd Date dictated 3/4/45

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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.