

FILED OCT 4 1948

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: St. Luke's Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 Week (Specify whether
In this community 25 Years (Specify whether
years, months or days)

3. (a) PRINT FULL NAME ALBERT FRANKLIN GAINES
3. (b) If veteran, name war Spanish American 3. (c) Social Security No. 486-26-8815

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Rosezetta Gaines 6. (c) Age of husband or wife if alive 59 years
7. Birth date of deceased August 2nd 1874
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
72 1 14 hr. min.

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

10. Usual occupation Parking Lot Operator

11. Industry or business

12. Name Samuel M. Gaines

13. Birthplace Missouri
(City, town, or county) (State or foreign country)

14. Maiden name Julia Ann Holbrook

15. Birthplace Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Rosezetta Gaines

(b) Address 1419 Bellefontaine

17. (a) Burial (b) Date thereof 9 - 18 - 1948
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Elmwood Cemetery

18. (a) Signature of funeral director Freeman Mortuary & Chapel

(b) Address 104 West 42nd St. Kansas City, Mo.

19. (a) 9-18-48 (b) Geraldine Holmes
(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. 1419 Bellefontaine
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month September day 16th.
year 1946 hour minute M.

21. I hereby certify that I attended the deceased from Sept. 9 1946 to Sept. 16 1946
that I last saw him alive on Sept. 16 1946
and that death occurred on the date and hour stated above.

Immediate cause of death Intestinal Obstruction Duration 3 mo.
Carcinoma (cancer) Caecum

Due to Carcinoma (cancer) Caecum

Other conditions 462
(Include pregnancy within 3 months of death)

Major findings: Ca. Caecum
Of operations

Of autopsy Peritonitis, broncho pneumonia

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)

While at work? (e) Means of injury

23. Signature W. Ziegler (M. D. or other)

Address 600 Prop Bldg Date signed 9-17-48

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

2
45
39
147070

48
3
8
0

MOTHER FATHER

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

OCT 4 1946

28-4-10-10-10

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..... *H. Freeman*

Licensed Embalmer No. 2939

P. O. Address F. O. 240.

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.