

FILED NOV 20 1946  
1946

Registration District No. \_\_\_\_\_

Primary Registration District No. 1002

Registrar's No. 4629

1. PLACE OF DEATH:

(a) County JACKSON  
 (b) City or town KANSAS CITY, MO.  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
FAIRMOUNT HOSPITAL  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 10 hrs. 45 min.  
 (Specify whether  
 In this community 10 HRS. - 45 MIN.  
 year, 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. 1414 E 27  
 (If rural, give location)  
 (e) Citizen of foreign country? U.S.A. (Yes or No)  
 If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME

GEORGE GRIFFEE

MEDICAL CERTIFICATION

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

20. DATE OF DEATH: Month Nov. day 1  
 year 1946 hour 10 minute 35 P.M.

4. Sex MALE 5. Color or race WHITES  
 6. (a) Single, widowed, married, divorced single  
 6. (b) Name of husband or wife \_\_\_\_\_  
 6. (c) Age of husband or wife if alive X years  
 7. Birth date of deceased NOV 1 - 1946  
 (Month) (Day) (Year)

21. I hereby certify that I attended the deceased from NOV 1  
1946, to NOV 1, 1946  
 that I last saw H.A.A. alive on NOV 1, 1946  
 and that death occurred on the date and hour stated above.

8. AGE:	Years	Months	Days	If less than one day
	0	0	0	10 hr. 45 min.

Immediate cause of death  
Congestive atelectasis  
 Due to Pneumonia  
Abruptio Placenta

Duration

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

Other conditions  
 (Include pregnancy within 3 months of death)  
1600

10. Usual occupation infant  
 11. Industry or business \_\_\_\_\_

Major findings:  
 Of operations \_\_\_\_\_  
 Of autopsy None

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

MOTHER FATHER

12. Name JAMES MONROE  
 13. Birthplace INDIANAPOLIS IND.  
 (City, town, or county) (State or foreign country)  
 14. Maiden name DEE GRIFFEE  
 15. Birthplace INDIANAPOLIS IND.  
 (City, town, or county) (State or foreign country)

16. (a) Informant FAIRMOUNT HOSPITAL  
 (b) Address 1414 E 27

17. (a) Burial (b) Date thereof Nov 6 46  
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Green Lawn

18. (a) Signature of funeral director A.P. Doehler  
 (b) Address 1415 East 15

19. (a) 11-4-46 (b) Gertrude Holmes  
 (Date received local registrar) (Registrar's signature)

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 Joseph P. Farney M.D. (M. D. or other)  
 Address 305 Brookside Dr. Date signed 11-1-46

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

3804

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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.**