

Registration District No. 149 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:  
General Hospital No. 1  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 2 mos. 16 days  
(Specify whether  
 In this community life  
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. 1333 Grand  
(If rural, give location)  
 (e) Citizen of foreign country? no (Yes or No)  
 If yes, name country \_\_\_\_\_

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

**MEDICAL CERTIFICATION**  
 20. DATE OF DEATH: Month May day 8  
 year 1947 hour 1 minute A. M.

4. Sex Male 5. Color or race Wht  
 6. (a) Single, widowed, married, divorced widowed  
 6. (b) Name of husband or wife unknown 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
 7. Birth date of deceased August 31 1879  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Feb. 21 1947 to May 8 1947  
 that I last saw him alive on May 8 1947  
 and that death occurred on the date and hour stated above.

**8. AGE:** Years 67 Months 8 Days 27  
 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

Immediate cause of death Carcinoma of stomach with peritoneal spread  
 Due to \_\_\_\_\_  
 Due to \_\_\_\_\_

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

Other conditions: 466  
(Include pregnancy within 3 months of death)

10. Usual occupation Hotel Clerk

Major findings:  
 Of operations \_\_\_\_\_  
 Of autopsy \_\_\_\_\_

MOTHER FATHER

11. Industry or business \_\_\_\_\_  
 12. Name Peter Clauson Fielding  
 13. Birthplace Penn  
(City, town, or county) (State or foreign country)  
 14. Maiden name Sarah Bella Phillips  
 15. Birthplace Lockport New York  
(City, town, or county) (State or foreign country)

Physician See above  
 Underline the cause to which death should be charged statistically.

16. (a) Informant Mrs. John Curran  
 (b) Address 1619 E 40 KC Mo

22. If death was due to external causes, fill in the following:  
 (a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
 (b) Date of occurrence \_\_\_\_\_

17. (a) removed (b) Date thereof 5-8-47  
(Burial, cremation, or removal) (Month) (Day) (Year)

(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? C

(c) Place: burial or cremation Maple Hill Cem KC Mo

While at work? \_\_\_\_\_  
(Specify type of place) (e) Means of injury

18. (a) Signature of funeral director Simmons  
 (b) Address 1404 S. 37 KC Mo  
 19. (a) 5-9-47 (b) Geraldine Holmes  
(Date received local registrar) (Registrar's signature)

23. Signature Wm W Hart (M. D. or other) MD  
 Address Med. Dir. Gen'l Hosp. Date signed 5-8-47

*Dr. Jackson*

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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..... *H Simmons* .....

Licensed Embalmer No. *3903* .....

P. O. Address..... *KPKa* .....

**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.**