

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 **3 days**
(Specify whether years, months or days)

In this community **45 years**

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. **414 E. 10 St.**
(If rural, give location)

(e) Citizen of foreign country? **no** (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME **Adam L. Spear**

3. (b) If veteran, name war **No**

3. (c) Social Security No. **492-14-6272**

4. Sex **Male** **5. Color of race** **White**

6. (a) Single, widowed, married, divorced **Divorced**

6. (b) Name of husband or wife **Lucille M. Spear**

6. (c) Age of husband or wife if alive **55 years**

7. Birth date of deceased. **August 18, 1884**
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **May** day **22** year **1947** hour **8** minute **12 A.** M.

21. I hereby certify that I attended the deceased from **May 19** 19**47**, to **May 22** 19**47**;
that I last saw him alive on **May 22** 19**47**;
and that death occurred on the date and hour stated above.

8. AGE:

Years	Months	Days	If less than one day
62	9	4	hr. mid.

Immediate cause of death
Acute pulmonary congestion secondary to myocardial infarction

Due to

9. Birthplace **Dubuque, Iowa**
(City, town, or county) (State or foreign country)

10. Usual occupation **Bookkeeper**

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

MOTHER FATHER

11. Industry or business

12. Name **John Spear**

13. Birthplace **Iowa**
(State or foreign country)

14. Maiden name **Margaret Roach**
(State or foreign country)

15. Birthplace **Iowa**
(State or foreign country)

PHYSICIAN

Underline the cause to which death should be charged statistically.

None

16. (a) Informant **Mrs. Lucille M. Spear**

(b) Address **428 West 59th Terrace.**

17. (a) Burial **(b) Date thereof** **May 26, 1947**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Mt. St. Marys**

18. (a) Signature of funeral director **Thos. E. Quirk**
(b) Address **4316 Troost Ave.**

19. (a) 5-24-47 **(b) Geraldine Holms**
(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?

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

23. Signature **Wm W. Hart** **(M. D. or other)** **MD**
Address **Med. Dir. Gen'l Hosp.** **Date signed** **5-22-47**

Handwritten scribbles

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 *Thomas E. Zwick*
.....
Licensed Embalmer No. *3775*
.....
P. O. Address *K.C. Mo*
.....

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.