

Registration District No. 150

Primary Registration District No. 5572

Registrar's No. 229

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Rural Prairie
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Jackson County Eng Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 week
(Specify whether years, months or days) unknown

2. USUAL RESIDENCE OF DECEASED:

(a) State unknown (b) County unknown
(c) City or town unknown
(If outside city or town limits, write "RURAL")
(d) Street No. unknown
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME

James Speck

3. (b) If veteran, name war -7- 3. (c) Social Security No. -7-

4. Sex Male 5. Color or race wh. 6. (a) Single, widowed, married, divorced -7-9
6. (b) Name of husband or wife -7- 6. (c) Age of husband or wife if alive ✓ years
7. Birth date of deceased June 14 72
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
75 6 16 hr. min.

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

10. Usual occupation _____

11. Industry or business _____

12. Name _____

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

14. Maiden name _____
15. Birthplace _____ (City, town, or county) (State or foreign country)

16. (a) Informant Records Jackson Co Hosp

(b) Address Independence Mo R.R.

17. (a) Autopsy (b) Date thereof 12-26-47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation K.C. Univ Dent

18. (a) Signature of funeral director W.B. Langford

(b) Address Leis Summit

19. (a) DEC 26 1947 (b) Ronald C. Samshaw
(Date received local registrar) (Registrar's signature) 379

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 12/24/47 year _____ hour _____ M.
minute _____

21. I hereby certify that I attended the deceased from 9/21/47 to 12/24/47, 19____; that I last saw him alive on 12/24/47, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death: Chronic Tuberculosis pneumonia
Due to _____

Due to Tertiary Syphilis
Other conditions None
(Include pregnancy within 3 months of death)

Major findings: None
Of operations _____
Of autopsy None

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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 _____ (Specify type of place)
about home, on farm, in industrial place, in public place?

(Specify type of place) _____
(c) Means of injury _____
Signature Ronald C. Samshaw (M. D. or other) _____
Date 12/28/47

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

18
3

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..... *N. B. Blaneyford*

Licensed Embalmer No. *3233*

P. O. Address *Leis Summit*

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.