

DEC 11 1939 395
Registration District No. 395

Primary Registration District No. 100

Registrar's No. 4440

1. PLACE OF DEATH:
(a) County Jackson
(b) City or town Kansas City
(c) Name of hospital or institution: H.C. Sun Hosp
(If not in hospital or institution, write street number & location)
(d) Length of stay: In hospital or institution 4 days
(Specify whether
In this community unk years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MO (b) County Jackson
(c) City or town Kansas City
(If outside city or town limits, write "RURAL")
(d) Street No. 523 Grand
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

3. (a) PRINT FULL NAME Jessie F Workman
62.5
(b) If veteran, name war unk (c) Social Security No. 70

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Nov day 19
year 1939 hour 4:00 minute am
21. I hereby certify that I attended the deceased from Nov
15-39, 19, to 11-19-39, 19;
that I last saw him alive on 11-19-39, 19;
and that death occurred on the date and hour stated above.

4. Sex M 5. Color or race W
6. (a) Single, widowed, married, divorced D
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased: June 30 1887
(Month) (Day) (Year)

Immediate cause of death Deleterial Duration _____
Branch pneumonia
Right Heart Deleterial

8. AGE: Years 52. Months 4 Days 19 If less than one day _____ hr. _____ min.

Due to Ruptured Peptic Ulcer
Due to _____

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

10. Usual occupation Farmer

Other conditions 117 a'
(Include pregnancy within 3 months of death)

MOTHER FATHER
11. Industry or business _____
12. Name Simon Workman
13. Birthplace MO
(City, town, or county) (State or foreign country)
14. Maiden name Reynolds
15. Birthplace MO
(City, town, or county) (State or foreign country)

Major findings:
Of operations _____
Of autopsy Schulze
PHYSICIAN _____
Underline the cause to which death should be charged statistically

16. (a) Informant's own signature Record Clerk
(b) Address H.C. Sun Hosp

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? _____

17. (a) Removal (b) Date thereof 11-21-39
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Jefferson City, Mo.

18. (a) Signature of funeral director D. W. Reynolds
(b) Address 1101 Grand Street
19. (a) Nov 20 1939 (b) M. M. Brown
(Date received local registrar) (Registrar's signature)

While at work? _____ (Specify type of place) (e) Means of injury _____
23. Signature Dr. D. M. ... (M. D. or other) _____
Address H.C. Sun Hosp (Where signed)

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

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

44

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 *George M. Collier*

Licensed Embalmer No. *3839*

P. O. Address *R.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, above space should be left blank.