

Registration District No. 399 Primary Registration District No. 100

1. PLACE OF DEATH: DEPT 11 1939  
(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  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
In this community \_\_\_\_\_ (Specify whether years, months or days) Unknown

2. USUAL RESIDENCE OF DECEASED:  
(a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
(c) City or town Kansas City  
(If outside city or town limits, write "RURAL")  
(d) Street No. 722 1/2 Main St  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

3. (a) PRINT FULL NAME George R oszell 240  
3. (b) If veteran, name war Und 3. (c) Social Security No. Und

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month 11-26-39 year \_\_\_\_\_ hour \_\_\_\_\_ M.  
21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_; the \_\_\_\_\_ of \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above.

4. Sex M 5. Color or race \_\_\_\_\_ 6. (a) Single, widowed, married, divorced Widowed  
6. (b) Name of husband or wife Unknown 6. (c) Age of husband or wife if alive Und years  
7. Birth date of deceased Unknown  
(Month) (Day) (Year)

Immediate cause of death Septicemias  
Due to meningococcus 1939  
Due to \_\_\_\_\_  
Other conditions Barlospneum  
(Include preexisting within 3 months of death)

8. AGE: Years \_\_\_\_\_ Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.  
About 72

Physician \_\_\_\_\_  
Underline the cause to which death should be charged statistically

9. Birthplace Und (City, town, or county) (State or foreign country)  
10. Usual occupation Und  
11. Industry or business Und  
12. Name Und  
13. Birthplace Und (City, town, or county) (State or foreign country)  
14. Maiden name Und  
15. Birthplace Und (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Cornora Dept City  
(b) Address \_\_\_\_\_  
17. (a) burial (Burial, cremation, or removal) (b) Date thereof 11/28/39 (Month) (Day) (Year)  
(c) Place: burial or cremation GreenLawn  
18. (a) Signature of funeral director A. Sebeto J.C.  
(b) Address 901 E. 5th  
19. (a) Nov 28, 1939 (Date received local registrar) (b) M. M. Crowe (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 Cassellinger (M. D. of other) \_\_\_\_\_  
Address \_\_\_\_\_ Date 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.

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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.....

*Ray E Snow*

Licensed Embalmer No. *2560*

P. O. Address. *901 E 5-*

**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.**