

JAN 13 1940  
Registration District No. 399Primary Registration District No. 1002

## 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:  
K. C. Gen. Hosp. No. 1  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 6 days  
6 days (Specify whether  
 In this community  
 years, months or days)

3. (a) PRINT FULL NAME Greer infant 6603. (b) If veteran,  
name war --- No3. (c) Social Security  
No. No4. Sex Male 5. Color or race White 6. (a) Single, widowed, married,  
divorced Single6. (b) Name of husband or wife --- 6. (c) Age of husband or wife if  
alive --- years7. Birth date of deceased Nov. 20th 1939  
(Month) (Day) (Year)8. AGE: Years Months Days If less than one day  
6 hr. min.9. Birthplace Kansas City Missouri  
(City, town, or county) (State or foreign country)10. Usual occupation child11. Industry or business ---12. Name Kenneth Greer13. Birthplace Joplin Mo.  
(City, town, or county) (State or foreign country)14. Maiden name Dorothy Barnes15. Birthplace Leavenworth Ks.  
(City, town, or county) (State or foreign country)16. (a) Informant's own signature Record Clerk(b) Address K. C. Gen. Hosp. No. 117. (a) Burial (b) Date thereof Dec. 6 39  
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation Greenlawn18. (a) Signature of funeral director Wailart Funeral Home(b) Address 2332 Monitor Pl. K. C. Mo.19. (a) Dec 5, 1939 (b) M. M. K. Crowe  
(Date received local registrar) (Registrar's signature)

## 2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson  
 (c) City or town Kansas City, Missouri  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. 1505 Pennsylvania  
 (If rural, give location)  
 (e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

## MEDICAL CERTIFICATION

20. DATE OF DEATH, Month Dec. day 4th  
year 1939 hour 12 minute 50 A.M. M.21. I hereby certify that I attended the deceased from 11-29-39  
to 12-4-39, 19\_\_\_\_, to 12-4-39, 19\_\_\_\_;  
that I last saw h im alive on 12-4-39, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

Immediate cause of death

Bronchopneumonia(Primary)

Due to

Due to

Other conditions  
(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy See above

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? 1 (Specify type of place)  
(e) Means of injury \_\_\_\_\_23. Signature P. F. De Maria M.D. (M. D. or other)Address Supt. K. C. General Hosp. Date signed \_\_\_\_\_

Duration

PHYSICIAN

Underline  
the cause to  
which death  
should be  
charged stati-  
stically

**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 \_\_\_\_\_

Licensed Embalmer No. \_\_\_\_\_

P. O. Address \_\_\_\_\_

**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.**