

Registration District No. **399**

Primary Registration District No. **2002**

1. PLACE OF DEATH:

(a) County **Jackson**
(b) City or town **Kansas City, Mo.**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
General Hospital No. 2
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **12-15 to 12-18-39**
(Specify whether
In this community **Unknown**
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")
Street No. **578 Forest (Basement)**
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **12** day **18**
year **39** hour **1** minute **44** P. M.
21. I hereby certify that I attended the deceased from
12-15, 19**39**, to **12-18**, 19**39**
that I last saw him alive on **12-18**, 19**39**
and that death occurred on the date and hour stated above.

Immediate cause of death
Uremia
Due to **Chronic Nephritis**
Hypertension

Other conditions
(Include pregnancy within 3 months of death)
Major findings:
Of operations _____
Of autopsy _____
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 or about home, on farm, in industrial place, in public place?
While at work? _____ (Specify type of place) _____ Means of injury _____
23. Signature **[Signature]** (M.D. or other)
Address **General Hospital #2** Date signed **12-19-**

3. (a) PRINT FULL NAME **John Hustin** **235**
3. (b) If veteran, name war **None** 3. (c) Social Security No. **None**

4. Sex **Male** 5. Color or race **Negro** 6. (a) Single, widowed, married, divorced **Widowed**

6. (b) Name of husband or wife **Unknown** 6. (c) Age of husband or wife if alive **--** years

7. Birth date of deceased **3** (Month) **15** (Day) **1857** (Year)

8. AGE: Years **82** Months **9** Days **3** If less than one day _____ hr. _____ min.

9. Birthplace **Springfield Ill.** (City, town, or county) (State or foreign country)

10. Usual occupation **none**

11. Industry or business _____

12. Name **Unknown**

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

14. Maiden name **Unknown**

15. Birthplace **Unknown** (City, town, or county) (State or foreign country)

16. (a) Informant's own signature **Record Clerk**

(b) Address **General Hospital No. 2**

17. (a) **Burial** (b) Date thereof **12-21-39** (Month) (Day) (Year)

(c) Place: burial or cremation **Lincoln Cemetery**

18. (a) Signature of funeral director **Lydia**
(b) Address **1729 Lydia**

19. (a) **Dec. 21, 1939** (b) **[Signature]** (Date received local registrar) (Registrar's signature)

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.

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

Isaac Jerome Manlove

Licensed Embalmer No.

3994

P. O. Address

1120 E. 23rd St.

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.