

WRITE PLAINLY—USE UNFADING INK—MAKING A LEGIBLE 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.

Registration District No. **399** Primary Registration District No. **1002**

JAN 13 1940

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. General Hospital No. 1
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 day
(Specify whether Life)

In this community Life
years, months or days

3. (a) PRINT FULL NAME Will Sellers 467

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

4. Sex Male **5. Color or race** White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Uda Sellers **6. (c) Age of husband or wife if alive** 68 years

7. Birth date of deceased Jan. 9 1869
(Month) (Day) (Year)

8. AGE: Years 70 Months 11 Days 17 If less than one day
hr. min.

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

10. Usual occupation Retired

11. Industry or business 0

MOTHER FATHER

12. Name Elizabeth M. Sellers

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

14. Maiden name Mantua Agnew

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

16. (a) Informant's own signature Reed Clark

(b) Address K.C. General Hosp.

17. (a) Burial **(b) Date thereof** 12-28-39
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Brooking

18. (a) Signature of funeral director Waller Funeral Home

(b) Address 2532 Monitor Place

19. (a) Dec. 28, 1939 **(b) M. M. Brown**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson

(c) City or town Kansas City
(If outside city or town limits, write "RURAL")

(d) Street No. 1013 Bellefontaine
(If rural, give location)

(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 12 day 26
year 39 hour 9 minute 50 P. M.

21. I hereby certify that I attended the deceased from 12-25
1939, to 12-26-39, 19____;

that I last saw h im on 12-26-39, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death _____ **Duration**
Ascending plastic peritonitis

Due to Perforated gall bladder

Due to Acute and chronic cholecystitis
and cholelithiasis.

Other conditions _____ 126
(Include pregnancy within 3 months of death)

Major findings: 0
Of operations _____

Of autopsy See above.

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? 1 (Specify type of place)
(e) Means of injury

23. Signature P. H. De Haven (M. D. or other)
Address Supt. K.C. Gen. Hosp. K.C. Mo. Date signed 12-27-39

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. *4075*

P. O. Address *2332 Monitor Rd*

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.