

Registration District No. _____

Primary Registration District No. _____

Registrar's No. 1990

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: 110 West 5th St. 2
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
(Specify whether years, months or days)
 In this community Unknown

3. (a) PRINT FULL NAME Clarence Harwood

8. (b) If veteran, name war. Unknown 8. (c) Social Security No. Unknown

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

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Feb 15 1870
(Month) (Day) (Year)

8. AGE: Years 69 Months 10 Days 5 If less than one day _____ hr. _____ min.

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

10. Usual occupation not known

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 _____

(b) Address _____

17. (a) Central Caf (b) Date thereof Jan 8-40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Central Caf of East

18. (a) Signature of funeral director Ketter

(b) Address 2657 Endy Ave

19. (a) 12-31-39 (b) M. M. Rawe
(Date received local registrar) (Registrar's signature)

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. 110 West 5th St.
(If rural, give location)
 (e) If foreign born, how long in U. S. A. Unknown years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ day 12-20-39
 year _____ hour _____ minute _____ M.

21. I hereby certify that I attended deceased from 6:30 a.m.
physician _____, 19____, to _____, 19____;
 and that death occurred on the date and hour stated above.

Immediate cause of death Chronic myocarditis
 Due to _____

Due to _____

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

Major findings: Of operations _____

Of autopsy None

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) (State of injury)

23. Signature M. M. Rawe (M. D. or other) _____

Address K.C., Mo. Date signed _____

PHYSICIAN

Underline the cause to which death should be charged statistically

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..... *Wm L Ward*.....

Licensed Embalmer No. *3991*.....

P. O. Address *5725 Virginia*.....

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.