

WHILE IN PRINT - 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.

Registration District No. 399

Primary Registration District No. 1002

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 12-30 to 1-2-40
(Specify whether)

In this community 6 years
years, months or days

3. (a) PRINT FULL NAME Noah Lee

8. (b) If veteran, name war No

8. (c) Social Security No. No

4. Sex Male

5. Color or race Negro

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: 12 (Month) 25 (Day) 1860 (Year)

8. AGE:

Years	Months	Days	If less than one day
79	0	7	hr. min.

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

10. Usual occupation none

11. Industry or business

MOTHER FATHER

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) Removal (b) Date thereof 1-6-40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Marshall Mo.

18. (a) Signature of funeral director H. B. Moore

(b) Address 1920 - 78 St.

19. (a) Jan. 5, 1940 (b) M. H. Crown
(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. 1416 E. 12th St.
(If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 1 day 2
year 1940 hour 9 minute 40 a.m.

21. I hereby certify that I attended the deceased from 12-30, 1939 to 1-2, 1940
that I last saw him alive on 1-2-, 1940:
and that death occurred on the date and hour stated above.

Immediate cause of death Broncho-Pneumonia

Due to 10 7/2

Due to

Other conditions
(Include pregnancy within 3 months of death)

PHYSICIAN

Major findings:
Of operations

Of autopsy

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 (Specify)

23. Signature [Signature] (M. D. or other)

Address General Hospital #2 Date signed 1-4-

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

AB Moore

Licensed Embalmer No. *2410*

P. O. Address *Kansas City, Mo.*

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.