

WRITE PLAINLY—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**
(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 **20 days** (Specify whether
In this community **14 years** years, months or days)

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. **2630 E. 29th St.**
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

3. (a) PRINT FULL NAME **REV. GEORGE MCNAB** **251**

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

4. Sex **M.** 5. Color or race **W.** 6. (a) Single, widowed, married, divorced **Mar.**

6. (b) Name of husband or wife **Anna H. McNab** 6. (c) Age of husband or wife if alive **78** years

7. Birth date of deceased **May 6th 1856**
(Month) (Day) (Year)

8. AGE: Years **83** Months **8** Days **14** If less than one day _____ hr. _____ min.

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

10. Usual occupation **Minister**

11. Industry or business _____

12. Name **Daniel McNab**

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

14. Maiden name **Elizabeth Elliott**
(City, town, or county) (State or foreign country)

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

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

(b) Address **K.C. General Hospital**

17. (a) **Chillith Mo** (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director **Rose Henderson**

(b) Address **15th Jackson K.C. Mo**

19. (a) **Jan. 22, 1940** (b) **M. M. Crowe**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Jan.** day **20th**
year **1940** hour **4** minute **20 P.** M.

21. I hereby certify that I attended the deceased from **Jan. 1st**, 19**40**, to **Jan. 20th, 1940**; that I last saw him alive on **Jan. 20th 1940**, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death **Uremia** Duration _____

Due to **Hypertensive cardio renal disease**

Due to **95%**

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? _____

(Specify type of place) While at work? _____ (e) Means of injury _____

23. Signature **Dr. De Maria MD** (M. D. or other) **1-22-40**
Address **Supt. K.C. Gen. Hospital** Date signed _____

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 1322

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 399

Primary Registration District No. 1002

Registrar's No. 307

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

R

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Jackson
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution.
In this community. (Specify whether years, months or days)

3. (a) PRINT FULL NAME Rev Geo. McHale

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

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced m
6. (b) Name of husband or wife. 6. (c) Age of husband, or wife, if alive. year
7. Birth date of deceased. (Month) (Day) (Year)

8. AGE: Years 83 Months 8 Days 14 If less than one day min.

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

10. Usual occupation.

11. Industry or business.

12. Name.

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

14. Maiden name.

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

16. (a) Informant.

(b) Address.

17. (a) (b) Date thereof. (Month) (Day) (Year)

(c) Place: burial or cremation.

18. (a) Signature of funeral director.

(b) Address 1/22/40 (c) M. M. Crowe

19. (a) (Date received local registrar) (b) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

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

MEDICAL CERTIFICATION

20. DATE OF DEATH. Month Jan day 20 year 1940 hour minute M.

21. I hereby certify that I attended the deceased from 19 to 19 that I last saw him alive on and that death occurred on the date and hour stated above. Immediate cause of death.

Due to.

Due to.

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

Major findings: Of operations.

Of autopsy.

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) (e) Means of injury.

23. Signature. Prof. DeMarino (M. D. or other)

Address. Date signed.

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

SUPPLEMENTARY

