

FILED MAR 11 1940

Registration District No. **399**

Primary Registration District No. **1002**

Registrar's No. **857**

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: **St. Marys hospital**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **2 days** (Specify whether
In this community **2 years**
years, months or days)

8. (a) PRINT FULL NAME **Chas. Sumner Moore**
3. (b) If veteran, name war ********* 3. (c) Social Security No. **NO**

4. Sex **M** 5. Color or race **W** 6. (a) Single, widowed, married, divorced **Married**
6. (b) Name of husband or wife **Carrie Moore** 6. (c) Age of husband or wife if alive **61** years
7. Birth date of deceased **Oct. 26, 1869**
(Month) (Day) (Year)

8. AGE: Years **80** Months **3** Days **28** If less than one day
hr. min. **Ohio**

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

10. Usual occupation **Retired Conductor**

11. Industry or business **M K & T**

12. Name **Albert Moore**

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

14. Maiden name **Anna Kuedler**

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

16. (a) Informant **Mrs. Carrie Moore**

(b) Address **3705 Euclid**

17. (a) **Burial** (b) Date thereof **2-26-40**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Crown Hill Cem.**

18. (a) Signature of funeral director **Mrs. C. L. Forster**
(b) Address **918 Brooklyn KCM.**

19. (a) **2-25-40** (b) **M. M. Crewe**
(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. **3705 Euclid**
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Feb.** day **24**
year **1940** hour _____ minute _____ AM.

21. I hereby certify that I attended the deceased from **2/20/40** to **2/20/40**, 19____; that I last saw him alive on **2/24/40**, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death **Cerebral Thrombosis** Duration **2 1/2** hours

Due to **Arteriosclerosis**

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 **M. M. Crewe** (M. D. or other) _____
Address **1401 E. 27th** Date signed **2/24/40**

PHYSICIAN
Underline the cause to which death should be charged statistically.

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

1401 S. W. Bul.
LO. 0450
get Dr. 12:15pm.

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.