

Registration District No. 399Primary Registration District No. 1002Registrar's No. 1123

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) 1
 (d) Length of stay: In hospital or institution 2 days
 (Specify whether
 In this community 22 years
 years, months or days)

8. (a) PRINT FULL NAME WILLIAM VANDERGRIF 5313. (b) If veteran, name war None 3. (c) Social Security No. None4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Divorced6. (b) Name of husband or wife Irene 6. (c) Age of husband or wife if alive Unk years7. Birth date of deceased January 22 1890
(Month) (Day) (Year)8. AGE: Years Months Days If less than one day
50 1 16 hr. min.9. Birthplace Illinois
(City, town, or county) (State or foreign country)10. Usual occupation Common Laborer
W. P. A.

11. Industry or business

MOTHER FATHER
 { 12. Name No Record
 { 18. Birthplace No Record
 (City, town, or county) (State or foreign country)
 { 14. Maiden name Mary McCully
 { 15. Birthplace No Record
 (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Jana Patricia Vandergriff
(b) Address 1213 Troost, K. C., Mo.17. (a) Burial (b) Date thereof Mar. 10, 1940
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Memorial Park, K. C. Ks.18. (a) Signature of funeral director Sheil Funeral Home
(b) Address 6606 Indep. Ave.19. (a) Mch 11, 1940 (b) M. M. Crow
(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. 906 E. 11thst Room 4
 (If rural, give location)
 (e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 8th
year 1940 hour 8 minute 45 A. M.21. I hereby certify that I attended the deceased from 3-6-40, 19____, to 3-8-40, 19____;
that I last saw im alive on 3-8-40, 19____;
and that death occurred on the date and hour stated above.Immediate cause of death Syphilitic aortitis with aneurysm and erosion into trachea

Due to _____

Due to 34 _____

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy See above

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 P. J. De Maria MD. (M. D. or other)
Address Supt. K. C. Gen. Hospital, K. C. Mo. Date signed _____

PHYSICIAN

Underline the cause to which death should be charged statistically.

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 Joe B. Yoder, Registered Apprentice No. # 233
working under my personal supervision.

Signed

J.P. Sheil

Licensed Embalmer No. 3625

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.