

Registration District No. 399

Primary Registration District No. 1002

Registrar's No. 1174

1. PLACE OF DEATH:  
 (a) County Jackson  
 (b) City or town Kansas City  
 (c) Name of hospital or institution: Research Hospital  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 22 days  
 In this community 6 months  
 (Specify whether 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. 523 Grand Ave.  
 (If rural, give location)  
 (e) If foreign born, how long in U. S. A. \_\_\_\_\_ years

3. (a) PRINT FULL NAME JOHN J. PERRY 600  
 3. (b) If veteran, name war. No 3. (c) Social Security No. None

MEDICAL CERTIFICATION  
 20. DATE OF DEATH: Month Mar. day 13th  
 year 1940 hour 9 minute 50 P. M.

4. Sex Male 5. Color or race Wh  
 6. (a) Single, widowed, married, divorced Sgl  
 6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
 7. Birth date of deceased Sept. 30, 1908  
 (Month) (Day) (Year)

21. I hereby certify that I attended the deceased from February 21, 1940, to March 13, 1940;  
 that I last saw him alive on March 13, 1940, and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day  
31 5 13 hr. min.

Immediate cause of death  
Lobar Pneumonia, Bilateral  
Meningitis (Staphylococci)  
 Due to \_\_\_\_\_  
 Due to \_\_\_\_\_

Duration  
4 days  
4 days  
 PHYSICIAN  
 Underline the cause to which death should be charged statistically

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

10. Usual occupation Farm Laborer

11. Industry or business  
 12. Name John A. Perry  
 18. Birthplace Schuyler County Mo.  
 (City, town, or county) (State or foreign country)

Other conditions (include pregnancy within 3 months of death)  
 Major findings: Meningitis Cerebral Acute,  
Right Frontal Lobe of Brain  
 Of autopsy \_\_\_\_\_

MOTHER FATHER  
 14. Maiden name Emma Reisinger  
 15. Birthplace Guernsey County Iowa  
 (City, town, or county) (State or foreign country)

16. (a) Informant's own signature John A. Perry  
 (b) Address 5332 Highland  
 17. (a) Burial (b) Date thereof 3-15-40  
 (Burial, cremation, or removal) (Month) (Day) (Year)

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? \_\_\_\_\_

(c) Place: burial or cremation Maple Hill - Kansas  
 18. (a) Signature of funeral director J. M. Wagner  
 (b) Address Kansas City, Mo.

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_  
 23. Signature Donald F. Caburn (M. D. or other) M.D.  
 Address 1630 Professional Bldg Date signed Mar 14/40

19. (a) Mch 15, 1940 (b) M. M. Crowe  
 (Date received local registrar) (Registrar's signature)

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

Rev. 6-17-39 1 x10511

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.

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**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 Cecil R. Matthes

Licensed Embalmer No. 3807

P. O. Address X.C. 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.**