

Registration District No. 399

Primary Registration District No. 1002

Registrar's No. 1290

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:  
General Hospital No. 2  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 2-20-40-3-22-40  
(Specify whether  
In this community Unknown  
years, months or days)

3. (a) PRINT FULL NAME Henry Perry 600

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

4. Sex Male 5. Color or race Negro 6. (a) Single, widowed, married, divorced Widow

6. (b) Name of husband or wife Unknown 6. (c) Age of husband or wife if alive -- years

7. Birth date of deceased 3 16 1874  
(Month) (Day) (Year)

8. AGE: Years 66 Months 0 Days 6 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation Barbecue Man

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name Unknown  
18. 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 #2

17. (a) Removal (b) Date thereof 3-23-40  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Osceola, Ark.

18. (a) Signature of funeral director Samuel Greenstreet

(b) Address 1819 - 3715

19. (a) Mch 24, 1940 (b) M.M. Crowe  
(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. 1627 E. 19th St.  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. ? \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 3 day 22  
year 40 hour 5 minute 55 A.M.

21. I hereby certify that I attended the deceased from 2-20- 19 40 o. 3-22- 19 40  
that I last saw him alive on 3-22- 19 40:  
and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia, Broncho

Due to Inter-current Infection

Due to Syphilitic Heart Disease

Other conditions 24  
(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 J. C. Turner (M. D. or other) \_\_\_\_\_  
Address General Hospital #2 Date signed 3-23-

Duration \_\_\_\_\_  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically

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

Rev. 6-17-39 1 x1511

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.

**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 Edw. J. Evans

Licensed Embalmer No. 3876

P. O. Address 1819 E. 15th St. 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.**