

Registration District No. 399

Primary Registration District No. 1002

Registrar's No. _____

1. PLACE OF DEATH: Jackson

(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. Gener. Hospital No. 1
(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 No record years, months or days)

3. (a) PRINT FULL NAME ORVILLE BAKER 260

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

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

6. (b) Name of husband or wife No record 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased No record
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>55</u>			hr. _____ min.

9. Birthplace No record
(City, town, or county) (State or foreign country)

10. Usual occupation No record

11. Industry or business _____

MOTHER FATHER { 12. Name No record 13. Birthplace No record
(City, town, or county) (State or foreign country)

MOTHER FATHER { 14. Maiden name No record 15. Birthplace No record
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Record clerk
(b) Address K.C. General Hospital

17. (a) Burial (b) Date thereof 3-29-40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Leeds

18. (a) Signature of funeral director W.A. Lohmeyer
(b) Address K.C. Gen. Hosp. No. 1

19. (a) Mch 28, 1940 (b) N.M. Crowe
(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. 1017 Holmes St.
(If rural, give location)

(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 3rd
year 1940 hour 6 minute 50 P. M.

21. I hereby certify that I attended the deceased from 2-1-40, 19____, to 3-3-40, 19____;
that I last saw him alive on 3-3-40, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death Hypertensive heart disease

Due to _____

Due to _____

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

Major findings: Of operations _____

Of autopsy None

Duration _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

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

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.

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 Wm A. Lehman

Licensed Embalmer No. 3089

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.