

MAY 15 1940

399

Registration District No. _____

Primary Registration District No. _____

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

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:
LaSalle Hotel--- **2**
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____
(Specify whether years, months or days)

In this community 50 Years

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. LaSalle Hotel
(If rural, give location)

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

3. (a) PRINT FULL NAME Mr. Samuel Weeks Heyward **650**

(b) If veteran, name war No

(c) Social Security No. 490-16-0059

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 24th
year 1940 hour 6 minute 45 P. M.

4. Sex Male 5. Color or race White

6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Mrs. Gertrude Falk Heyward

6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased June 3 1849
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from 1-5-40
_____, 19____, to _____, 19____;
that I last saw him alive on 4-10-40
and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day

90 10 21 hr. _____ min.

Immediate cause of death
Coronary Occlusion **1 hour**

Due to _____

Due to _____

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

Other conditions Arterio sclerosis
(Include pregnancy within 3 months of death)

10. Usual occupation Night Superintendant

11. Industry or business Composing Room-K.C. Star

MOTHER FATHER

12. Name Unknown Heyward

13. Birthplace Brooklyn New York
(City, town, or county) (State or foreign country)

14. Maiden name UNKNOWN

15. Birthplace Rhode Island
(City, town, or county) (State or foreign country)

PHYSICIAN

Major findings:
Of operations _____

Of autopsy _____

Underline the cause to which death should be charged statistically.

16. (a) Informant Clare Garian

(b) Address LaSalle Hotel

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

17. (a) Mt. Moriah (b) Date thereof 4-27-40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Moriah Cem

(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? _____

18. (a) Signature of funeral director W. H. Newcomer's Son

(b) Address 1401 Brush Creek Blvd.

While at work? _____ (Specify type of place)

(e) Means of injury 1

19. (a) 4-25-40 (b) M. M. Crowe
(Date received local registrar) (Registrar's signature)

23. Signature W. H. Newcomer's Son (M. D. or other) _____
Address 1408 W. 11th St. P.O. Box Date signed 4-25-40

1:30-5 except Thursdays

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.....

R. C. Newcomer Jr.

Licensed Embalmer No.....

41043

P. O. Address.....

R. C. Mc-

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.