

JUN 17 1940 399

Registration District No.

Primary Registration District No. 1002

State File No.

Registrar's No. 2009

1. PLACE OF DEATH

(a) County Jackson
(b) City or town Kansas City Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 1735 Forest Ave. 2
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution none
(Specify whether years, months or days) unknown

3. (a) PRINT FULL NAME George Wodds

3. (b) If veteran, name war no 3. (c) Social Security No. 710

4. Sex male 5. Color or race negro 6. (a) Single, widowed, married, divorced unk

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

7. Birth date of deceased unknown
(Month) (Day) (Year)

8. AGE: Years 58 Months Days If less than one day hr. min.

9. Birthplace K.C. MO.
(City, town, or county) (State or foreign country)

10. Usual occupation laborer

11. Industry or business laborer

MOTHER FATHER { 12. Name unknown

13. 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 None

(b) Address None

17. (a) Burial (b) Date thereof 5-15-40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Blue Ridge

18. (a) Signature of funeral director Deal

(b) Address 1409 E 12th

19. (a) May 14, 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. 1735 Forest Ave
(If rural, give location)
(e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 5 day 9 year 1940 hour 7 minute 20 A. M.

21. I hereby certify that I attended the deceased from _____, 19____

that I last saw _____, 19____

and that death occurred on the date and hour stated above.

Immediate cause of death _____ Duration _____

Peritonitis & Lungemia

Due to cyber

Due to Sticker & Bronch

Other conditions 1250

(Include pregnancy within 3 months of death)

PHYSICIAN _____

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 Russell Jensen (M. D. or other) _____

Address TC Date signed _____

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

Rev. 5-17-39

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 *W. P. Harris, Jr.*

Licensed Embalmer No. *3388*

P. O. Address. *K.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.