

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.

FILED JUN 17 1940

Registration District No. **399**

Primary Registration District No. **1002**

Registrar's No. **2059**

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: The Childrens Mercy Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 30 hours
(Specify whether
In this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Jackson
(c) City or town Blue Springs Mo
(If outside city or town limits, write "RURAL")
(d) Street No. _____
(If rural, give location)
(e) If foreign born, how long in U. S. A? _____ years.

3. (a) PRINT FULL NAME Charles Argo
Charles Argo 620

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

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

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

7. Birth date of deceased May 4 1930
(Month) (Day) (Year)

8. AGE: Years 10 Months _____ Days 14 If less than one day hr. _____ min. _____

9. Birthplace Jackson Co Mo
(City, town, or county) (State or foreign country)

10. Usual occupation School Child

11. Industry or business _____

12. Name Ralph Argo

13. Birthplace _____
(City, town, or county) (State or foreign country)

14. Maiden name Opal
15. Birthplace Mo
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Ralph Argo
(b) Address Blue Springs Mo

17. (a) Removal (b) Date thereof 5-20-40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Blue Springs Mo

18. (a) Signature of funeral director R. B. Webb
(b) Address Blue Springs Mo

19. (a) May 19, 1940 (b) M. M. Brown
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 18
year 1940 hour 9 minute 45 M.

21. I hereby certify that I attended the deceased from May 17, 1940
19____, to May 18, 1940 19____;
that I last saw him alive on May 18, 1940, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death Diabetes mellitus Duration 3 days
Diabetic Coma

Due to Acute Mena Pharyngitis 4 days

Due to _____

Other conditions none 59
(include pregnancy within 3 months of death)

Major findings: _____
Of operations none

Of autopsy NO

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 J. C. Clin M.D. (M. D. or other)
Address 632 Prof. B. B. Moore Date signed 5/18/40

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.....

Licensed Embalmer No.....

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.