

Registration District No. **399**

Primary Registration District No. **1002**

Registrar's No. **2132**

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 #2
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **5-2-40-5-8-40**
(Specify whether
In this community **Unknown**
years, months or days)

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. **560 Harrison**
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **5** day **8**
year **40** hour **4** minute **45 A.M.**

21. I hereby certify that I attended the deceased from **5-2-**, 19 **40**, to **5-8-**, 19 **40**;
that I last saw him alive on **5-8-40**, 19 **40**;
and that death occurred on the date and hour stated above.

Immediate cause of death
Chronic Nephritis with Uremia.

Duration

Due to **131**

Due to _____

Other conditions
(Include pregnancy within 3 months of death)

PHYSICIAN

Major findings:
Of operations _____

Of autopsy _____

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?
361
While at work? _____ (Specify type of place)
(e) Means of injury _____

23. Signature **B. O. Burdick** (M. D. or other)
Address **Gen. Hosp. #2** Date signed **5-10-**

3. (a) PRINT FULL NAME **Robert Grant** **653**

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

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

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

7. Birth date of deceased. **8** **18** **1904**
(Month) (Day) (Year)

8. AGE: Years **35** Months **8** Days **20** If less than one day
hr. _____ min.

9. Birthplace **Mo.** **0**
(City, town, or county) (State or foreign country)

10. Usual occupation **none** **9**

11. Industry or business _____

12. Name **Unknown** **9**

13. Birthplace **Unknown** **9**
(City, town, or county) (State or foreign country)

14. Maiden name **Sally**
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) **Burial** (b) Date thereof **5** **1940**
(Burial, cremation, or removal) (Month), (Day) (Year)
(c) Place: burial or cremation **K. C. College of Osteopathy**

18. (a) Signature of funeral director **Irving E. Brady**
(b) Address **1513 Trost**

19. (a) **May 24, 1940** (b) **M. M. Craibe**
(Date received local registrar) (Registrar's signature)

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.....

L. J. Harris

Licensed Embalmer No.

5388

P. O. Address.....

K. C. 240

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.