

Registration District No. 399

Primary Registration District No. 1002

Registrar's No.

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:
Kansas City General Hosp
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 4 months (Specify whether years, months or days)

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. 712 - E - 8th
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 5 day 23 year 1940 hour _____ minute _____ M.
21. I hereby certify that People the deceased from 12:45 P.M. 19____; that he was alive on _____ 19____; and that death occurred on the date and hour stated above.
Immediate cause of death: stab wounds of the back

Separation of the lung & hemo-pneumothorax (left)
Laceration of both kidneys
e retroperitoneal hemorrhage

Other conditions (Include pregnancy within 3 months of death)
Major findings:
Of operations:
Of autopsy:
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) Homicide
(b) Date of occurrence 5-24-40
(c) Where did injury occur? K.C. Mo (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, or in a public place? in a public place

While at work? _____ (Specify type of place)
23. Signature Victor M. Buel (City or town) (County) (State)
Address K.C. Mo Date signed _____

3. (a) PRINT FULL NAME OPAL MAY LOUTHAIN

3. (b) If veteran, name war NA 3. (c) Social Security No. None

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

6. (b) Name of husband or wife Arthur Louthain 6. (c) Age of husband or wife if alive 22 years

7. Birth date of deceased May 8-1920 (Month) (Day) (Year)

8. AGE: Years 20 Months 15 If less than one day hr. _____ min. _____

9. Birthplace Mason Missouri (City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business _____

12. Name Austin Cook

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

14. Maiden name Estie Walker

15. Birthplace Libby Missouri (City, town, or county) (State or foreign country)

16. (a) Informant Austin Cook

(b) Address Mason Missouri

17. (a) Remove (b) Date thereon May 25-1940 (Month) (Day) (Year)

(c) Place: burial or cremation Mason Missouri

18. (a) Signature of funeral director First Funeral Home

(b) Address Kansas City Mo
19. (a) May 24, 1940 (Date received local registrar) (b) F.M.M. Craue (Registrar's signature)

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

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 the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.