

Registration District No. 399 Primary Registration District No. 1002

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 No. 2
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 5-13-40-5-23-40
(Specify whether
In this community 20 years
years, months or days)

3. (a) PRINT FULL NAME Lynn Jackson 250
3. (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 9 13 1891
(Month) (Day) (Year)

8. AGE: Years 68 Months 8 Days 10 If less than one day hr. min.

9. Birthplace Miss. 1
(City, town, or county) (State or foreign country)

10. Usual occupation none

11. Industry or business
12. Name Unknown David Jackson
13. Birthplace Unknown
14. Maiden name Unknown
15. Birthplace Unknown
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Record Clerk
(b) Address General Hospital No. 2.

17. (a) Burial (b) Date of removal 5-27-40
(Burial, cremation, or removal) (Month) (Day) (Year)

18. (a) Signature of funeral director Julius A. ...
(b) Address ...

19. (a) May 27, 1940 (b) M. M. Crome
(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. 1024 Woodland, 1st floor.
(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 40 hour 8 minute 35 A. M.

21. I hereby certify that I attended the deceased from 5-13- 19 40, to 5-23- 19 40, that I last saw h. im alive on 5-23- 19 40; and that death occurred on the date and hour stated above.

Immediate cause of death Circulatory Failure

Due to Probable Cerebral Hemorrhage

Due to _____

Other conditions (Include pregnancy within 3 months of death) 82K

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)
Means of injury _____

23. Signature es O. ... (M. D. or other)
Address Gen. Hosp. #2. Date signed 5-23-

Duration _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically

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

Julius A. H. Feiler
.....
Licensed Embalmer No. *2229*
P. O. Address *1212 Vine St*

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.