

Registration District No. **399** Primary Registration District No. **1002**

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:
Union Station Kansas City Terminal Ry. Co.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether
In this community **32** years, months or days) _____

3. (a) PRINT FULL NAME **William R. Poe**
3. (b) If veteran, name war **No** 3. (c) Social Security No. **703-03-9220**

4. Sex **Male** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Divorced**
6. (b) Name of husband or wife **Frances** 6. (c) Age of husband or wife if alive **--** years
7. Birth date of deceased **Sept 18 1905**
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	34	8	13	hr. 0 min. 0

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

10. Usual occupation **Electrician**

11. Industry or business **Kansas City Terminal Ry Co.**

MOTHER FATHER
12. Name **Edgar A. Poe**
13. Birthplace **Missouri**
(City, town, or county) (State or foreign country)
14. Maiden name **Leona Gorin**
15. Birthplace **Missouri**
(City, town, or county) (State or foreign country)

16. (a) Informant **Edgar A. Poe**
(b) Address **5218 Wilburn Court**

17. (a) **Burial** (b) Date thereof **6-4-1940**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Missouri City, Mo**

18. (a) Signature of funeral director **Mrs. C.L. Forster**
(b) Address **918 Brooklyn Kansas City Mo.**

19. (a) **June 3, 1940** (b) **M. M. Brown**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County **Jackson**
(c) City or town **Kansas City Mo.**
(If outside city or town limits, write "RURAL")
(d) Street No. **5218 Wilburn Court**
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **June** day **1**
year **1940** hour **11** minute **10 A.** M.

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

Immediate cause of death
Fresh Injury Head & Chest
Fract. Skull & Sac. Spine
Fall Down Elevator Shaft
Due to _____
Due to _____
Other conditions (Include pregnancy within 3 months of death) **2027**

Duration

Major findings: Of operations _____
Of autopsy **Above**

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) **Accidental**
(b) Date of occurrence **10-1-40**
(c) Where did injury occur? **Family Jackson Mo**
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
Indus

While at work? **Yes** (Specify type of place) **Fall Down Elevator Shaft**
(e) Means of injury

23. Signature **[Signature]** (M. D. or other) _____
Address _____ Date signed _____

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 Theron A. Redmon

Licensed Embalmer No. 2737

P. O. Address H.P.M.

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.