

MAKE SURE TO 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.

Registration District No. 399

Primary Registration District No. 1002

Registrar's No. 2389

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 5-6-40-6-9-40
21 years (Specify whether
 In this community
 years, months or days)

3. (a) PRINT FULL NAME Barbey Lennox 521
 (b) If veteran, name war No
 (c) Social Security No. 496-09-0029

4. Sex Male
 5. Color or race Negro
 6. (a) Single, widowed, married, divorced Widowed
 6. (b) Name of husband or wife Minnie Lenox
 6. (c) Age of husband or wife if alive years 10 28 1896
 7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years 43 Months 7 Days 12
 If less than one day hr. min.

9. Birthplace Valdosta Georgia
 (City, town, or county) (State or foreign country)
 10. Usual occupation Laborer

11. Industry or business
 12. Name Floyd Lennox
 13. Birthplace Valdosta Georgia
 (State or foreign country)
 14. Maiden name Queen Crawford
 15. Birthplace Valdosta Georgia
 (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Record Clerk
 (b) Address General Hospital #2

17. (a) Burial (Burial, cremation, or removal) Highland (City or town) (County) (State)
 (b) Date thereof 6-13-1940 (Month) (Day) (Year)
 (c) Place: burial or cremation Blue Ridge Cemetery

18. (a) Signature of funeral director West, Appleton & Jones
 (b) Address 1905 Vine
 (c) Date received local registrar June 11, 1940
 (d) Registrar's signature M. M. Crome

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. 2324 Highland Ave.
 (If rural, give location)
 (e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month 6 day 9
 year 40 hour 3 minute A. M.
 21. I hereby certify that I attended the deceased from 5-6- 1940 to 6-9- 1940
 that I last saw h. 1m alive on 6-9- 1940
 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage
 Duration
 Due to Hemiplegia (Right) 42N
 Due to
 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)
 (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 [Signature] (M. D. or other)
 Address Gen. Hosp. #2 Date signed 6-11-

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 C. J. West

Licensed Embalmer No. 2710

P. O. Address 1905 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.