

WHOLE FAMILY—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

1. PLACE OF DEATH:
(a) County Jackson
(b) City or town Kansas City
(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 5-3-40-6-7-40
In this community 50 years
(Specify whether years, months or days)

8. (a) PRINT FULL NAME John Dickerson 262
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 _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased 8 12 1881
(Month) (Day) (Year)

8. AGE: Years 58 Months 6 Days 26 If less than one day _____ hr. _____ min.

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

10. Usual occupation none 0

11. Industry or business _____

MOTHER FATHER { 12. Name Unknown
18. Birthplace Unknown
(City, town, or county) (State or foreign country)

MOTHER FATHER { 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 #2

17. (a) burial (b) Date thereof 6-13-40
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Blue Ridge Lawn

18. (a) Signature of funeral director H. B. Moore
(b) Address 1820 E-18th St

19. (a) June 11-40 (b) M. M. Crowe
(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. 1730 Troost Ave., 2nd Fl
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month 6 day 7
year 40 hour 6 minute 35 A. M.

21. I hereby certify that I attended the deceased from 5-3- 40 to 6-7- 40
that I last saw him 1m alive on 6-7- 40
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Nephritis with Uremia. Duration _____

Due to Arteriosclerosis. 131

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) Means of injury 1

23. Signature J. C. Shuman (M. D. or other) _____
Address Gen. Hosp. #2 Date signed 6-8-

1 X 19511

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 me
AB Moore, Registered Apprentice No. _____
working under my personal supervision.

Signed AB Moore
Licensed Embalmer No. 2410

P. O. Address 1820 E 18 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.