

Registration District No.

Primary Registration District No.

1002

Registrar's No.

2497

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 5-7-40-6-16-40
15 years (Specify whether years, months or days)

In this community _____ years, months or days

3. (a) PRINT FULL NAME Russell Holmes 4523. (b) If veteran, name war No3. (c) Social Security Had not filed4. Sex Male 5. Color or race Negro 6. (a) Single, widowed, married, divorced Married6. (b) Name of husband or wife Unknown 6. (c) Age of husband or wife if alive Unknown years7. Birth date of deceased 1 19 1902
(Month) (Day) (Year)8. AGE: Years 38 Months 4 Days 27 If less than one day hr. min.9. Birthplace Kansas /
(City, town, or county) (State or foreign country)10. Usual occupation Pharmacist-Johnson Drug Co.11. Industry or business For self on Commission 912. Name Unknown 913. Birthplace Unknown14. Maiden name Unknown (City, town, or county) (State or foreign country)15. Birthplace Unknown (City, town, or county) (State or foreign country)16. (a) Informant's own signature Record Clerk(b) Address General Hospital #217. (a) West Lawn (b) Date thereof June 19, 1940
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation K.C. Kansas18. (a) Signature of funeral director E. J. Bills(b) Address 1811 E. 9th St. K.C. Mo.19. (a) June 18, 1940 (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. 1815 E. 9th St.
(If rural, give location)

(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 6 day 16
year 40 hour 10 minute A. M.21. I hereby certify that I attended the deceased from 5-7-, 1940, to 6-16-, 1940;
that I last saw him alive on 6-16-, 1940
and that death occurred on the date and hour stated above.Immediate cause of death Portal Cirrhosis of the Liver. Duration _____Due to 12403

Due to _____

Other conditions (Include pregnancy within 3 months of death)Major findings: Of operationsOf autopsy Above Mentioned.

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 J. O. Turner (M. D. or other) 6-16-
Address Gen. Hosp. #2 Date signed _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

FILED JUL 15 1940

399

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.....

E. S. Bills

Licensed Embalmer No. 3178

P. O. Address 1811 E. 12th 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.