

AUG 14 1940

Registration District No. 399

Primary Registration District No. 1002

Registrar's No.

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: K.C. General Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 22 days
In this community 35 Years (Specify whether years, months or days)

8. (a) PRINT FULL NAME FRED ACKERMAN 265

3. (b) If veteran, name war none 3. (c) Social Security No. none

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if _____
alive _____ years

7. Birth date of deceased: Don't Know
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
About 65 hr. min.

9. Birthplace: Don't Know 9
(City, town, or county) (State or foreign country)

10. Usual occupation Cook 9

11. Industry or business _____

MOTHER FATHER

12. Name: Don't Know 9

13. Birthplace: Don't Know 1
(City, town, or county) (State or foreign country)

14. Maiden name: Don't Know

15. Birthplace: Don't Know
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Jackson
(b) Address 524 A. East 15th

17. (a) Burial (b) Date thereof 7-25-40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Green Lawn

18. (a) Signature of funeral director Freeman Mortuary
(b) Address Kansas City, Mo.

19. (a) July 24, 1940 (b) M.M. Oslove
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson
(c) City or town Kansas City
(If outside city or town limits write "RURAL")
(d) Street No. 515 1/2 A Cherry
(If rural, give location)
(e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 23rd
year 1940 hour 9 min 50 A. M.

21. I hereby certify that I attended the deceased from July 1st 1940 to July 23rd 1940, 19____;
that I last saw him alive on July 23rd 1940, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death
Lobar pneumonia with abscess of right lung

Due to Cerebral arteriosclerosis and Generalized arteriosclerosis

Due to _____

Other conditions: _____
(Include pregnancy within 3 months of death)

Major findings:
Of operations: _____

Of autopsy: See above

Duration
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)
(a) Means of injury !

23. Signature Mary C. Thorn (M. D. or other)
Address Med. Dir. K.C. Gen. Hospital Date signed _____

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

STATE OF CALIFORNIA
DEPARTMENT OF PUBLIC HEALTH
BUREAU OF FUNERAL DIRECTORS
SAN FRANCISCO

NAME OF DECEASED
AGE
SEX
DATE OF DEATH
PLACE OF DEATH

PLACE OF INTERMENT
DATE OF INTERMENT
NAME OF FUNERAL HOME

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, or by.....

Signed Clarence W. Chiles

Licensed Embalmer No. 3473

P. O. Address 76 E 460

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.