

WRITE PLAINLY—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. 154399

Primary Registration District No. 1002

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.T.B. Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 10-3-39-8-2-40
(Specify whether
In this community 28
years, months or days)

3. (a) PRINT FULL NAME Mr. Neary, Georgia 256
3. (b) If veteran, name war No
3. (c) Social Security No. No

4. Sex Female 5. Color or race Neg-ro
6. (a) Single, widowed, married, divorced W. Dow

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

7. Birth date of deceased January 9 1884
(Month) (Day) (Year)

8. AGE: Years 56 Months 6 Days 23
If less than one day hr. min.

9. Birthplace Red River Texas
(City, town, or county) (State or foreign country)

10. Usual occupation maid

11. Industry or business
MOTHER FATHER { 12. Name Tattus Jim
13. Birthplace Texas
(City, town, or county) (State or foreign country)
14. Maiden name Patsy
15. Birthplace Texas
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature K.C.M.T.B. Hospital
(b) Address Reeds Station, Kansas City

17. (a) Burial (b) Date thereof 8-10-40
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Kirkville, Mo

18. (a) Signature of funeral director Flynn & Greenstreet
(b) Address 1819 E. 12th St. No.

19. (a) Aug. 9, 1940 (b) M.M. Crewe
(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. 1314 Pacific
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 2
year 1940 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from 8:15 PM
Oct 3 1939 to Aug 2 1940
that I last saw her alive on Aug 2 1940
and that death occurred on the date and hour stated above.

Immediate cause of death
Adv. pulmonary tuberculosis
Due to tuberculosis
Due to 20

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____
Of autopsy _____

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?

(Specify type of place) While at work _____ Means of injury _____

23. Signature [Signature] (M. D. or other) _____
Address City Date signed 8/2/40

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically

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

Edwin S. Thomas

Licensed Embalmer No.

3836

P. O. Address

1814 1/2 S. 4th St. KC Mo

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.