

Registration District No. **399**

Primary Registration District No. **1002**

Registrar's No. **3259**

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 **6-20-40-8-11-40**
(Specify whether
In this community **29 Years**
years, months or days)

8. (a) PRINT FULL NAME **Fred Vance (claimed as Frank Matthews)**

3. (b) If veteran, No name war. 3. (c) Social Security No. **710**

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

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

7. Birth date of deceased **1 9 1881**
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	59	7	2	hr. min.

9. Birthplace **Lincoln Nebraska**
(City, town, or county) (State or foreign country)

10. Usual occupation **Hod Carrier**

11. Industry or business

MOTHER FATHER { 12. Name **Frank Matthews**

18. Birthplace **Nebraska**
(City, town, or county) (State or foreign country)

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 **8-18-40**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Dale Ridge**

18. (a) Signature of funeral director **Doyle 360 361**

(b) Address **1708 Tracy**

19. (a) **Aug. 17, 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. **1803 E. 18th St.**
(If rural, give location)
(e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **8** day **11**
year **40** hour **8** minute **05 P.M.**

21. I hereby certify that I attended the deceased from **6-20-**, 19 **40**, **8-11-**, 19 **40**,
that I last saw him alive on **8-11-**, 19 **40**
and that death occurred on the date and hour stated above.

Immediate cause of death **Secondary Hemorrhage from Hemorrhagic Cyst.**

Due to **Hemorrhagic Cyst of Undetermined Nature. (Lumbar Region)**

Due to **Possible Carcinoma of G I Tract.**

Other conditions **n. m. o.**
(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? _____

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

23. Signature **G. O. D... #2** (M. D. or other)
Address **Gen. Hosp. #2** Date signed **8-12-**

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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.....

B. L. Graham

Licensed Embalmer No. *2540*

P. O. Address. *2208 Vine*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.