

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

Registration District No. **399**

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. General Hospital No. 1**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **3 Mo. & 12 days**
In this community **41 Yrs.**
(Specify whether years, months or days)

8. (a) PRINT FULL NAME **JAMES C. DEVIN** **150**
3. (b) If veteran, name war **no** 3. (c) Social Security No. **no**

4. Sex **male** 5. Color or race **wh.** 6. (a) Single, widowed, married, divorced **married**
6. (b) Name of husband or wife **Carrie K. Devin** 6. (c) Age of husband or wife if alive **65** years
7. Birth date of deceased **Feb. 10, 1871**
(Month) (Day) (Year)

8. AGE: Years **69** Months **7** Days **7** If less than one day hr. min.

9. Birthplace **Mad. City Kans.**
(City, town, or county) (State or foreign country)

10. Usual occupation **Retired**

11. Industry or business
MOTHER FATHER { 12. Name **James H. Devin**
13. Birthplace **Posy Co. Ind.**
(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 **Carrie K. Devin**
(b) Address **2131 E. 67**

17. (a) **Cremation** (b) Date thereof **Aug. 19 --4**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Elmwood Cremation**

18. (a) Signature of funeral director **Eylar Funeral Home**
(b) Address **K.C.M.O.**

19. (a) **Aug. 19, 1940** (b) **M. M. Crowe**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **0 Missouri** (b) County **Jackson**
(c) City or town **Kansas City, Missouri**
(If outside city or town limit, write "RURAL")
2131 E. 67th St.
(d) Street No. (If rural, give location)
(e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Aug** day **17th**
year **1940** hour **2** minute **40 P.** M.

21. I hereby certify that I attended the deceased from **May 7th**, 19 **40** to **Aug. 17th 1940**, 19 _____
that I last saw him alive on **Aug. 17th, 1940**, 19 _____
and that death occurred on the date and hour stated above.

Immediate cause of death **Toxemia**
Due to **Diabetic gangrene and diabetes**
Due to **59**
Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations _____
Of autopsy **None**
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)
(e) Means of injury _____
23. Signature **Quayle R. Howell** (M. D. or other)
Address **Med. Dir. K.C. Gen. Hospital, K.C. Mo.** Date signed _____

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 Chas Wells

Licensed Embalmer No. 2644

P. O. Address 1800 Penna

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.