

Registration District No. **399**

Primary Registration District No. **1002**

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

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 11 days (Specify whether
In this community 4 years years, months or days)

3. (a) PRINT FULL NAME PRESTON GREGG

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 Married

6. (b) Name of husband or wife Ella Gregg 6. (c) Age of husband or wife if alive 34 years

7. Birth date of deceased June 14 1908
(Month) (Day) (Year)

8. AGE: Years 32 Months 2 Days 13 If less than one day hr. min.

9. Birthplace Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation F armer

MOTHER FATHER

12. Name Joseph Gregg
13. Birthplace Missouri
(City, town, or county) (State or foreign country)
14. Maiden name Eliza Harris
15. Birthplace Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant Ella Jackson

(b) Address 6220 E. 16th Terrace

17. (a) Removal (b) Date thereof 8-28-30
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Creighton, Mo.

18. (e) Signature of funeral director G. W. Wagner

(b) Address Kansas City, Mo.

19. (a) Aug. 28, 1940 (b) M. M. Crause
(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 limit, write "RURAL")
(d) Street No. 6220 E. 16th St. Terrace
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. day 27th
year 1940 hour 8 minute 56 A. M.

21. I hereby certify that I attended the deceased from 8-16-40, 19____, to 8-27-40, 19____;

that I last saw him alive on 8-27-40, 19____, and that death occurred on the date and hour stated above.

Immediate cause of death Rheumatic heart disease

Due to _____

Due to _____

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

Major findings: _____
Of operations _____

Of autopsy See above

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)
(c) Means of injury _____

23. Signature D. R. Thorne (M. D. or other)
Address Med. Dir. N. Y. Gen. Hospital, K. C. Mo. Date signed _____

PHYSICIAN
Duration _____
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 Cecil R. Matthes

Licensed Embalmer No. 3807

P. O. Address K.C. 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.