

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:
General Hospital #2
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 8-20-40-8-24-40
(Specify whether
In this community Unknown
years, months or days)

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. 3231 Rockhill Road
(If rural, give location)
(e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 8 day 24
year 40 hour 10 minute 45 P. M.
21. I hereby certify that I attended the deceased from
8-20- 1940 to 8-24- 1940;
that I last saw her alive on 8-24- 1940;
and that death occurred on the date and hour stated above.

Duration

Immediate cause of death:
Carbuncle with Generalized Toxemia
Dilatation of Heart with Congestion

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

PHYSICIAN

Underline
the cause to
which death
should be
charged sta-
tistically.

Major findings:
Of operations _____
Of autopsy Above Mentioned

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?

3. (a) PRINT FULL NAME Josephine Robertson

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

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

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

7. Birth date of deceased _____
(Month) (Day) (Year)

8. AGE: Years 52 Months _____ Days _____ If less than one day
hr. _____ min. _____

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

10. Usual occupation Housework

11. Industry or business _____

12. Name Unknown

13. Birthplace Unk.
(City, town, or county) (State or foreign country)

14. Maiden name Unk.

15. Birthplace Unk.
(City, town, or county) (State or foreign country)

16. (a) Informant Record Clerk

(b) Address General Hospital #2

17. (a) Burial (b) Date thereof 9-6-40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Reeds

18. (a) Signature of funeral director [Signature]

(b) Address 112 E. 1st St.

19. (a) Sept. 6, 1940 (b) M. M. Brown
(Date received local registrar) (Registrar's signature)

23. (a) Signature [Signature] (b) While at work? _____ (c) Means of injury !
28. (a) Signature [Signature] (b) Address Gen. Hosp. #2 (c) Date signed 9-4-40
(M. D. or other)

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

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 Isaac Leone - Manlow

Licensed Embalmer No. 3994

P. O. Address 1120 E 23rd St.

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.