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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 31161

FILED OCT 11 1940

Registration District No. 399 — Primary Registration District No. 1002 — Registrar's No. 3724

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: 215 West 15th Street (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ____ (Specify whether years, months or days) In this community 40 years

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. 215 West 15th (If rural, give location)

(e) If foreign born, how long in U. S. A.? ____ years.

3. (a) PRINT FULL NAME WILLIAM L. TUTTLE

3. (b) If veteran, name war No

3. (c) Social Security No. 495-07-8083

4. Sex Male

5. Color or race White

6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Bessie

6. (c) Age of husband or wife if alive ____ years

7. Birth date of deceased April 6, 1880 (Month) (Day) (Year)

8. AGE: Years 60 | Months 5 | Days 18 | If less than one day ____ hr. ____ min.

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

10. Usual occupation Waiter

11. Industry or business ____

FATHER
12. Name No Record
13. Birthplace No Record (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name No Record
15. Birthplace No Record (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Wm Loyd Tuttle

(b) Address 4009 Elledge Rd, Johnson Co, Ks

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/26/40 (Month) (Day) (Year)

(c) Place: burial or cremation Memorial Park Cem.

18. (a) Signature of funeral director Quirk and Tobin Co.

(b) Address Kansas City, Mo

19. (a) 9-24-40 (Date received local registrar) (b) M. M. Crowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 24th year 1940 hour 10 minute 10 A.M.

21. I hereby certify that I attended the deceased from 4:30AM to 10:10AM Sept. 24, 1940, to ____, 19__; that I last saw him alive on Sept 24th 10:10 AM, 1940; and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Cerebral hemorrhage	10 hours
Due to Hypertension 82a	1 year
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy

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? (Specify type of place)

While at work? (e) Means of injury

23. Signature Ed H Klein (M. D. ~~or other~~)

Address Plaza Med. Bldg. Date signed 9/24/40

(Licensed Embalmer's Statement on Reverse Side)

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 Harold Perry

Licensed Embalmer No. 4097

P. O. Address K.C., Mo.

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

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