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10-39
-39
21492

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 **two days**
(Specify whether
In this community **41 years**
years, months or days)

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. **2641 East 8th Street**
(If rural, give location)
(e) If foreign born, how long in U. S. A. ? _____ years.

3. (a) PRINT FULL NAME **EVERETT KOONTZ (E.W.)**
3. (b) If veteran, name war **No 424**
3. (c) Social Security No. **No 499-14-3743**

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **Sept.** day **25th**
743 year **1940** hour **1** minute **25** A. M.

4. Sex **Male** 5. Color or race **Wh**
6. (a) Single, widowed, married, divorced **Widowed**
6. (b) Name of husband or wife **Eva Koontz**
6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased **Dec 9 1873**
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **Sept. 23rd** 19**40**, to **Sept. 25th** 19**40**;
that I last saw him alive on **Sept. 25th** 19**40**
and that death occurred on the date and hour stated above.
Immediate cause of death **Bleeding**
Duration

8. AGE: Years **66** Months **9** Days **16**
If less than one day hr. min.

Bronchopneumonia
Due to **Cerebral thrombosis with Encephalomalacia**
Due to **82 B**

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

Other conditions (Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy **See above**

10. Usual occupation **Cement Finisher**
11. Industry or business **0**
12. Name **George W Koontz**
13. Birthplace **Terra Haute Indiana**
(City, town, or county) (State or foreign country)
14. Maiden name **Sarah Arnold**
15. Birthplace **Booneville Missouri**
(City, town, or county) (State or foreign country)

PHYSICIAN
Underline the cause to which death should be charged statistically.

16. (a) Informant **Mrs. Robert Land**
(b) Address **2641 East 8**

17. (a) **Burial** (b) Date thereof **9/27/40**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Floral Hills Cemetery**

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?

18. (a) Signature of funeral director **Quirk & Tolson**
(b) Address **K.C. Mo.**
19. (a) **9-26-40** (b) **M. M. Brown**
(Date received local registrar) (Registrar's signature)

While at work? (Specify type of place) (e) Means of injury **1**
28. Signature **Dr. R. L. Thom** (M. D. or other)
Address **Med. Dir. K.C. Gen. Hospital** Date signed

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

MOTHER FATHER

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.....

R. C. Moore

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

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