

FILED NOV 1 1940

Registration District No. _____

Primary Registration District No. **1002**

Registrar's No. **3928**

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

I. 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 **9-24-40-10-9-40**
(Specify whether years, months or days) **20 years**

8. (a) PRINT FULL NAME **Beverley White**

8. (b) If veteran, name war **None** 3. (c) Social Security No. **496-16-6674**

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

6. (b) Name of husband or wife **Lula White** 6. (c) Age of husband or wife if alive **Unknown** years

7. Birth date of deceased **April 8 1887**
(Month) (Day) (Year)

8. AGE: Years **53** Months **6** Days **1** If less than one day hr. min.

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

10. Usual occupation **Custodian**

11. Industry or business _____

MOTHER FATHER { 12. Name **Unknown**

18. Birthplace **Unknown**
(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 **Record Clerk**

(b) Address **Gen. Hosp. #2**

17. (a) **burial** (b) Date thereof **10/11/40**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Highland Cemetery**

18. (a) Signature of funeral director **Stathian Bros.**

(b) Address **1729 Lydia**

19. (a) **10-11-40** (b) **M. M. Browe**
(Date received local registrar) (Registrar's signature)

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. **2309 Tracy**
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **10** day **9**
year **40** hour **12** minute **40 A.** M.

21. I hereby certify that I attended the deceased from **9-24-** 19 **40** to **10-9-** 19 **40**

that I last saw him alive on **10-9-** 19 **40** and that death occurred on the date and hour stated above.

Immediate cause of death **Eobar Pneumonia**

Due to **Hypertensive Type of Heart Disease**

Due to **Chronic Nephritis with Uremia**

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

Major findings: _____
Of operations _____

Of autopsy _____

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 **E. C. Brown** (M. D. or other)

Address **Ka. Mo.** Date signed _____

Duration

PHYSICIAN

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

Isaac Jerome Manlove

Licensed Embalmer No.

3994

P. O. Address

1125 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.