

Registration District No. **1947**

Primary Registration District No. _____

Registrar's No. **2077**

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 **9-24-40-10-3-40**
(Specify whether years, months or days)
In this community **30 years**

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. **1116 1/2 Campbell (rear)**
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **10** day **3**
year **40** hour **12** minute **A.** M.
21. I hereby certify that I attended the deceased from **9-24-** 19**40**, to **10-3-** 19**40**;
that I last saw him alive on **10-3-** 19**40**;
and that death occurred on the date and hour stated above.

Immediate cause of death **Hypertensive Type of Heart Disease**

Due to **Chronic Nephritis**

Due to _____

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) _____
Means of injury _____

23. Signature **[Signature]** (M. D. or other)
Address **[Address]** Date signed **10-4-40**

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

3. (a) PRINT FULL NAME **Frank Trent**

8. (b) If veteran, name war **No** 3. (c) Social Security No. **No**

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

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased. **8** **5** **1880**
(Month) (Day) (Year)

8. AGE: Years **60** Months **1** Days **28** If less than one day _____ hr. _____ min.

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

10. Usual occupation **House man**

11. Industry or business _____

12. Name **Unknown**

13. 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 **General Hospital #2**

17. (a) **Lincoln Cem.**, (b) Date thereof **10-14-40**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation: _____

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

(b) Address **1905 Vine st**

19. (a) **10-12-40** (b) **M. M. Brown**
(Date received local registrar) (Registrar's signature)

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 *C. H. West*

Licensed Embalmer No. *2710*

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.