No. 2
11-10-39
5-17-39
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 34591

FILED NOV 12 1940

Registration District No. [illegible]

Primary Registration District No. 1002

Registrar's No. 4107

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 years, months or days)

In this community: Unknown

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.: Oldham Hotel
(If rural, give location)

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

3. (a) PRINT FULL NAME: JOHN MAXWELL

3. (b) If veteran, name war: No

3. (c) Social Security No.: None

4. Sex: M

5. Color or race: W

6. (a) Single, widowed, married, divorced: Unknown

6. (b) Name of husband or wife: Unknown

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

7. Birth date of deceased: Unknown (Month) (Day) (Year)

8. AGE: Years: About 86 years; Months: ; Days: ; If less than one day: ____ hr. ____ min.

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

10. Usual occupation: Unknown

11. Industry or business:

MOTHER FATHER

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: Hospital Record.

(b) Address:

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: Oct 28 1940 (Month) (Day) (Year)

(c) Place: burial or cremation: Floral Hill

18. (a) Signature of funeral director: C. H. Blackmore

(b) Address: 9825 Indep. Blvd.

19. (a) 10-27-40 (Date received local registrar) (b) M. M. Orme (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month: Oct. day: 25th year: 1940 hour: 1 minute: 40 A M.

21. I hereby certify that I attended the deceased from 10-23-40, 19__, to 10-25-40, 19__; that I last saw him alive on 10-25-40, 19__; and that death occurred on the date and hour stated above.

Immediate cause of death: ~~Hypertension with Hypertrophy and dilatation of heart and Chronic vascular nephritis~~

Due to: Arterial sclerosis 131

Due to:

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

Major findings:
Of operations:

Of autopsy: See above

Duration

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: [illegible] (M. D. or other)

Address: Med. Dir. K. C. Gen. Hospital Date signed: 10-25-40

(Licensed Embalmers 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 B. H. Blackman

Licensed Embalmer No. 2244

P. O. Address.....

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.