

FILED NOV 12 1940
Registration District No. 699

State File No. 34601
Registrar's No. 4117

Primary Registration District No. 1002

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

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 5 days
(Specify whether
In this community No record
years, months or days)

3. (a) PRINT FULL NAME ALBERT CHEVALIER

3. (b) If veteran, name war No record 3. (c) Social Security No. _____

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced No record

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

7. Birth date of deceased No record
(Month) (Day) (Year)

8. AGE: Years App. 54 Months _____ Days _____ If less than one day
hr. _____ min. _____

9. Birthplace No record 9
(City, town, or county) (State or foreign country)

10. Usual occupation No record 9

11. Industry or business _____

MOTHER { 12. Name No record 9

13. Birthplace No record
(City, town, or county) (State or foreign country)

14. Maiden name No record

15. Birthplace No record
(City, town, or county) (State or foreign country)

16. (a) Informant Record Clerk

(b) Address K. C. General Hospital, K. C. Mo.

17. (a) Burial (b) Date thereof 10 29 40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Greenlawn

18. (a) Signature of funeral director Wailart Funeral Home

(b) Address 2332 Monitor Place, K. C. Mo.

19. (a) 10-28-40 (b) M. M. Crowe
(Date received local registrar) (Registrar's signature)

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. 0 Eastgate Hotel
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 24th
year 1940 hour 11 minute 23 P. M.

21. I hereby certify that I attended the deceased from 10-19-40, 19____, to 10-24-40, 19____;
that I last saw him alive on 10-24-40, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary Hemorrhage, cause not determined

Due to _____

Due to 23

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

Major findings: Of operations _____

Of autopsy None

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 _____

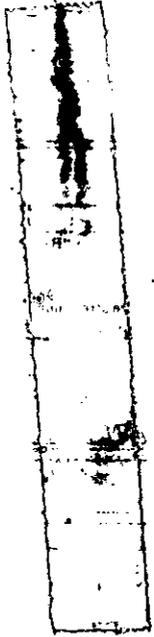
(c) Where did injury occur? _____
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

31 While at work _____ (Specify type of place) _____

23. Signature Wm. R. Stone (M. D. or other) _____

Address Med. Dir. K. C. Gen. Hospital, K. C. Mo. Date signed _____



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 *Blaine E. Weiland*

Licensed Embalmer No. *4075*

P. O. Address *2332 Montrose Place*

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. _____

Primary Registration District No. _____

Registrar's No. 4117

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Transas City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: General Hospital #
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether _____)
In this community _____ years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town Eastgate Hotel
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 24
year 1940 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw him _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death: Hemorrhage probably gastric not verified by autopsy
Due to _____
Due to 118 C

Other conditions: Chronic train
(Include pregnancy within 3 months of death)
Major findings: lyt. N. C.
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? _____

18. (a) Signature of funeral director _____
(b) Address _____
(c) Place: burial or cremation _____
(Specify type of place)
While at work? _____ (e) Means of injury _____
23. Signature Mary R. Stone (M. D. or other) _____
Address _____ Date signed _____

3. (a) PRINT FULL NAME Chevalier, Albert
(b) If veteran, name war _____ (c) Social Security No. _____

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

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

7. Birth date of deceased _____ (Month) _____ (Day) _____ (Year)

8. AGE: Years _____ Months _____ Days _____ If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

12. Name _____

13. Birthplace _____ (City, town, or county) _____ (State or foreign country)

14. Maiden name _____

15. Birthplace _____ (City, town, or county) _____ (State or foreign country)

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) _____ (Day) _____ (Year)
(Burial, cremation, or removal)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 1/27/40 (b) M. M. Brown
(Date received local registrar) (Registrar's signature)

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

SUPPLEMENTAL

S-32460

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.....

Licensed Embalmer No.....

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.