

Registration District No. **399**

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  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 2 days  
(Specify whether)  
In this community 20 years  
years, months or days

REC'D DEC 21 1940

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. 916 East 8th St.  
(If rural, give location)  
0  
(e) If foreign born, how long in U. S. A? \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 8th  
year 1940 hour 10 minute 40 A. M.

21. I hereby certify that I attended the deceased from 11-6-40, 19\_\_\_\_, to 11-8-40, 19\_\_\_\_;  
that I last saw him alive on 11-8-40, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

Immediate cause of death  
Carcinoma of oesophagus with perfora-  
tion of Bronchus and multiple lung  
abscesses

Due to \_\_\_\_\_  
Due to 46  
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? \_\_\_\_\_

(Specify type of place)  
While at work? \_\_\_\_\_ (e) Means of injury !  
28. Signature Dr. J. P. Brown (M. D. or other)  
Address Med. Dir. K.C. Gen. Hospital Date signed 11-9-40

3. (a) PRINT FULL NAME CHARLES W. GARFIELD  
3. (b) If veteran SS. 487-05-1998 name war No  
3. (c) Social Security No. Unknown

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced Married  
6. (b) Name of husband or wife Effie Garfield 6. (c) Age of husband or wife if alive 68 years  
7. Birth date of deceased Jan - Unk 1872  
(Month) (Day) (Year)

8. AGE: Years 68 Months 10 Days Unk If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation Cook

11. Industry or business Restaurant

MOTHER FATHER { 12. Name unknown  
13. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)  
14. Maiden name unknown  
15. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)

16. (a) Informant Charles W. Garfield  
(b) Address 916 E 8th

17. (a) None (b) Date thereof 11/11/40  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Green lawn

18. (a) Signature of funeral director R. E. Snow  
(b) Address 2315 Linwood Blvd  
19. (a) 11-11-40 (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 Roy E Snow

Licensed Embalmer No. 2560

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.**