No. 2
11-10-39
5-17-39
I X21492

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. 37748

Registration District No. 399 — Primary Registration District No. 1002 — Registrar's No. 4346

FILED DEC 11 1940

1. PLACE OF DEATH:

(a) County: Jackson

(b) City or town: Kansas City (If outside city or town limits, write "RURAL" and name 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: 6 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.: 810 E 15th St. (If rural, give location)

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

3. (a) PRINT FULL NAME: CHARLES HASTINGS

3. (b) If veteran, name war: ____ SS. 499-40-6657

3. (c) Social Security No.: Unk

4. Sex: Male

5. Color or race: White

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

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

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

7. Birth date of deceased: January (Month) 12th (Day), 1885 (Year)

8. AGE: Years 55 | Months 9 | Days 28 | If less than one day ____ hr. ____ min.

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

10. Usual occupation: Salesman

11. Industry or business: ____

FATHER

12. Name: Charles Hastings

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

MOTHER

14. Maiden name: Edith Rhodes

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

16. (a) Informant: Record Clerk

(b) Address: K.C. General Hospital

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 11-15-40 (Month) (Day) (Year)

(c) Place: burial or cremation: Gunlawn

18. (a) Signature of funeral director: Wm. A. Schmeyer

(b) Address: 1C Gen Hospital

19. (a) 11-15-40 (Date received local registrar) (b) M. M. Brown (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 9th year 1940 hour 7 minute 30 A. M.

21. I hereby certify that I attended the deceased from 11-3-40, 19__, to 11-9-40, 19__; that I last saw him alive on 11-9-40, 19__; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Auricular Fibrillation; Right Bundle Branch Block	
Due to:	
Due to:	
Other conditions (Include pregnancy within 3 months of death):	
Major findings: Of operations:	
Of autopsy: None	

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: Drury R. Jones (M. D. or other)

Address: Med. Dir. K.C. Gen. Hospital Date signed:

(Licensed Embalmer's 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 Wm A. Lohmeyer

Licensed Embalmer No. 3089

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wi the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.