

Registration District No. **399**

Primary Registration District No. **1002**

Registrar's No. **4372**

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 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 2 mo. & 24 days
(Specify whether
In this community 35 years
years, months or days)

3. (a) PRINT FULL NAME Clarence Elmer Hurst

3. (b) If veteran, name war _____ 3. (c) Social Security No. 495-10-2642

4. Sex Male 5. Color or race white 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 June 17th 1886
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
54 4 28 hr. min.

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

10. Usual occupation Bar tender

11. Industry or business _____

12. Name Alfred Hurst

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

14. Maiden name Elizabeth Kay

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

16. (a) Informant Record Clerk

(b) Address K.C. Gen. Hospital

17. (a) Removal (b) Date thereof 11-18-40
(Basic, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Burman Oaks

18. (a) Signature of funeral director W. M. Mark

(b) Address 3146 main

19. (a) 11-17-40 (b) M. M. Brown
(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. 523 West 12th St.
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 14th
year 1940 hour 10 minute 10 P. M.

21. I hereby certify that I attended the deceased from 8-20-40, 19____, to 11-14-40, 19____;
that I last saw him alive on 11-14-40, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death Luetic aortitis with aortic regurgitation

Due to _____
Due to _____

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

Major findings:
Of operations _____

Of autopsy None

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 Dr. R. P. Shaw (M. D. or other)
Address Med. Dir. K.C. Gen. Hospital Date signed _____

Duration
PHYSICIAN
Underline the cause to which death should be charged statistically.

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

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 *Howard J. Roe*.....

Licensed Embalmer No. *2748*.....

P. O. Address *1324 E 26 Ave*.....

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. 37774

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 399

Primary Registration District No. 1002

Registrar's No. 4372

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

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town KC
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(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)

3. (a) PRINT FULL NAME Clarence Elmer Hurst

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

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

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 54 Months 4 Days 28 If less than one day _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 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 11/17/40

19. (a) _____ (b) M. M. Crowe (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____ (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 Nov day 14
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 _____

Due to _____

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) (e) Means of injury _____

23. Signature Darsey R. Thoma M.D. or other _____

Address _____ Date signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

