

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  
(c) Name of hospital or institution: St. Mary's Hosp.  
(d) Length of stay: In hospital or institution 3 weeks  
In this community 20 yrs

2. USUAL RESIDENCE OF DECEASED:  
(a) State Mo (b) County Jackson  
City or town Kansas City  
Street No. 5315 Thompson  
(e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

3. (a) PRINT FULL NAME Andrew Dabney  
3. (b) If veteran, name war No 3. (c) Social Security No. 702-12-3416

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month Oct day 16 year 1940 hour 11:12 minute \_\_\_\_\_ A. M.

4. Sex Male 5. Color or race W 6. (a) Single, widowed, married, divorced Married  
6. (b) Name of husband or wife Lula Farney Dabney 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased Sept 26 1877

21. I hereby certify that I attended the deceased from Oct. 18 to Nov. 16 1940 that I last saw him alive on Nov. 16 and that death occurred on the date and hour stated above.  
Immediate cause of death Myocardial failure Duration 3 days

8. AGE: Years 63 Months 1 Days 20 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

Due to Chronic arterial essential hypertension  
Due to 87.5%

9. Birthplace Bolivar Mo  
10. Usual occupation Car Inspector

Other conditions Paralysis 10/18/40  
Cerebral hemorrhage

11. Industry or business K.C. Southern R.R.  
12. Name Wm Dabney  
13. Birthplace Mo  
14. Maiden name Mary Sears  
15. Birthplace Mo

Major findings:  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

16. (a) Informant Ralph Dabney  
(b) Address 1907 Brandon Ind  
17. (a) Burial (b) Date thereof 11/18/40  
(c) Place: burial or cremation Mt. Washington  
18. (a) Signature of funeral director John B. [unclear]  
(b) Address K.C. Mo  
19. (a) 11-18-40 (b) M. M. Brown

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 [unclear] (M. D. or other) \_\_\_\_\_  
Address 800 Argyle Bldg Date signed 11/16/40

**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, fact should be so stated above.**