

Registration District No. 399

Phy. Registration District No. 1002

Registrar's No. 4594

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 two days (Specify whether
In this community 3 Yrs.
years, months or days)

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. 2815 Tracy
(If rural, give location)
(e) If foreign born, how long in U. S. A. ? _____ years.

3. (a) PRINT FULL NAME JAMES RUSSELL HERRMAN

3. (b) If veteran, name war NO 3. (c) Social Security No. 494-14-7136

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 Sept. 1, 1922
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
18 2 16 _____ hr. _____ min.

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

10. Usual occupation School boy

11. Industry or business _____

12. Name H. K. Herrmann

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

14. Maiden name Rose Russell

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

16. (a) Informant H. K. Herrmann

(b) Address 2815 Tracy

17. (a) Burial (b) Date thereof 11-19-40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary

18. (a) Signature of funeral director Melody-McGilley

(b) Address City

19. (a) 11-18-40 (b) M. M. Brown
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 17th
year 1940 hour 10 minute 15 A. M.

21. I hereby certify that I attended the deceased from
11-15-40 19, to 11-17-40 19;
that I last saw him alive on 11-17-40 19,
and that death occurred on the date and hour stated above.

Immediate cause of death:
ACUTE BACTERIAL ENDOCARDITIS WITH
EMBOLISM TO BRAIN

Due to _____
Due to _____

Other conditions MULTIPLE INFARCTS OF LUNGS
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____
Of autopsy See above

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 Dr. R. Howard (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.

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.