

Registration District No. 399

Primary Registration District No. 1002

Registrar's No.

1. PLACE OF DEATH:

(a) County Jackson City  
(b) City or town Kansas City  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: St. Mary's Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 71 years (Specify whether 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. 103 W. 31st Terr.  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. ? \_\_\_\_\_ years.

3. (a) PRINT FULL NAME FRANK TIMMERMAN

8. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Bridget M. Kennedy 6. (c) Age of husband or wife if alive 70 years

7. Birth date of deceased November 22, 1869  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>71</u>	<u>11</u>	<u>25</u>	hr. _____ min. _____

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

10. Usual occupation Carpenter

11. Industry or business \_\_\_\_\_

12. Name Francis Timmerman

18. Birthplace Germany  
(City, town, or county) (State or foreign country)

14. Maiden name Sophie Koering

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

16. (a) Informant's own signature Mrs. Bridget Timmerman

(b) Address 103 W. 31st Terr.

17. (a) Burial (b) Date thereof 11/18/40  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Mary's Cem.

18. (a) Signature of funeral director J. J. & F. J. Co.

(b) Address H. C. Co.

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 11 day 17  
year 1940 hour 8 minute 30 M.

21. I hereby certify that I attended the deceased from NOV. 17 to NOV. 17, 1940  
that I last saw him alive on NOV. 16, 1940  
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral hemorrhage Duration 4 days  
hemiplegia  
left side paralysis  
Due to hypertension years  
General arterio sclerosis years

Other conditions (Include pregnancy within 3 months of death) None

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury 1

23. Signature F. J. Crowe (M. D. or other) ff

Address 810 Medical Bldg Date signed 11-18-40

WHILE FATHERLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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**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. *40975*

P. O. Address *K C Mo.*

**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.**