

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
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
3231 Prospect
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
In this community Life
years, months or days

FILED DEC 11 1940

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. 2816 Campbell
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

3. (a) PRINT FULL NAME JORDAN B. BEDFORD

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

4. Sex MALE 5. Color or race WH 6. (a) Single, widowed, married, divorced WID
6. (b) Name of husband or wife MACEY BEDFORD 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased APRIL 13 1847
(Month) (Day) (Year)

8. AGE: Years 93 Months 7 Days 12 If less than one day _____ hr. _____ min.

9. Birthplace MISSOURI
(City, town, or county) (State or foreign country)
10. Usual occupation RETIRED FARMER

11. Industry or business _____
12. Name JOHN BEDFORD
13. Birthplace VIRGINIA
(City, town, or county) (State or foreign country)
14. Maiden name MARY WHITSON
15. Birthplace VIRGINIA
(City, town, or county) (State or foreign country)

16. (a) Informant BEDFORD
(b) Address 2816 CAMPBELL
17. (a) BURIAL (b) Date thereof 11-29-40
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation MT. WASHINGTON

18. (a) Signature of funeral director MELLODY M'OLLEY
(b) Address R.C.M.O.
19. (a) Nov. 27, 1940 (b) M. M. Crowe
(Date received local registrar) (Registrar's signature)

MOTHER FATHER

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 11-25-40 day _____ year _____ hour 8 minute 45 A. M.
21. I hereby certify that I attended the deceased from 11-22-40 _____, 19____; to 11-22-40 _____, 19____; and that death occurred on the date and hour stated above.
that I last saw him alive on 11-22-40 _____, 19____;

Immediate cause of death Dehydration with terminal bronchial pneumonia.

Due to _____
Due to _____
10700

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

Duration

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) (c) Means of injury _____
23. Signature Dr. R. J. Shaw (M. D. or other) _____
Address Med. Dir., Gen. Hosp. Date signed _____

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.