

0-2
13-40
17-39
X23159

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:
Gen Hosp # 2
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether _____)
In this community Unknown
years, months or days

FILED DEC 11 1940

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Jackson

(c) City or town Kansas City
(If outside city or town limits, write "RURAL")

(d) Street No. 1622 Cherry
(If rural, give location)

(e) If foreign born, how long in U. S. A. ? _____ years.

3. (a) PRINT FULL NAME FRANK SHEROAD

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

4. Sex male 5. Color or race Negro 6. (a) Single, widowed, married, divorced Unknown

6. (b) Name of husband or wife Unknown 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Unknown
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

About 80 hr. _____ min.

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

10. Usual occupation Unknown 9

11. Industry or business Unknown 9

12. Name Unknown 9

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

14. Maiden name Unknown

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

16. (a) Informant E. Stebing Kille

(b) Address 1811 E. 17th St

17. (a) K.C. Mo (b) Date thereof 11-26-40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Western Dental College

18. (a) Signature of funeral director E. Stebing Kille

(b) Address 1811 E. 17th St. K.C. Mo

19. (a) NOV. 27, 1940 (b) M.M. Orlove
(Date received local registrar) (Registrar's signature)

(Licensed Embalmer's Statement on Reverse Side)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 11 day 17 year _____ hour _____ minute 30 A. M.

21. I hereby certify that I attended the deceased from _____, 19____; that I last saw _____ alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death: Chronic Myocarditis

Due to _____

Due to _____ 93c

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

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? _____

(e) Means of injury _____

23. Signature Quellert (M. D. or other) _____

Address _____ 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: *C. Steving Bells*

Licensed Embalmer No. *3178*

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, fact should be so stated above.