

No. 2
-13-40
17-39
X23159

Registration District No. 399 Primary Registration District No. Registrar's No.

FILED DEC 11 1940

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: 4021 Walnut
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2
In this community. Life
years, months or days (Specify whether)

3. (a) PRINT FULL NAME. James Graham Hazell
(b) If veteran name war No (c) Social Security No. No

4. Sex Male 5. Color or race white 6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife Edna Rose Hazell 6. (c) Age of husband or wife if alive 13 years
7. Birth date of deceased Oct. 13, 1885
(Month) (Day) (Year)

8. AGE: Years 55 Months 1 Days 15 If less than one day hr. min.

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

10. Usual occupation Wholesale leather

11. Industry or business

12. Name Charles W. Hazell

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

14. Maiden name Harriett Mitchell

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

16. (a) Informant Mrs. Edna Rose Hazell

(b) Address 4021 Walnut

17. (a) Burial (b) Date thereof Nov 30, 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Forest Hill

18. (a) Signature of funeral director Freeman Mortuary

(b) Address 104 West 42nd Street

19. (a) 11-28-40 (b) M. B. Crowe
(Date received local registrar) (Registrar's signature)

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. 4021 Walnut
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 28th
year 1940 hour 5 minutes 20 A. M.

21. I hereby certify that I attended the deceased from November 12
1940, to Nov. 28, 1940
that I last saw him alive on November 28, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Coronary thrombosis Duration 20 days

Due to Coronary sclerosis

Due to _____

Other conditions Urinary suppression with terminal uremia Duration 2 days
(Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

Duration
20 days
1
2 days
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) None

(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 Graham Asher (M. D. or other) M.D.

Address 1220 Prof. Bldg. Date signed 11-28-40

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MOTHER FATHER

9470

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

Clarence St. Child

Licensed Embalmer No.

3473

P. O. Address

96 E 760

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No.

Primary Registration District No.

Registrar's No. 4540

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town K.C.
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
In this community _____ (Specify whether
years, months or days)

3. (a) PRINT FULL NAME

James G. Hazell

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex M

5. Color or race W

6. (a) Single, widowed, married, divorced M

6. (b) Name of husband or wife _____

6. (c) Age of husband, or wife, if alive _____ years

7. Birth date of deceased _____

(Month) (Day) (Year)

8. AGE:

Years _____ Months _____ Days _____
If less than one year _____ hr. _____ min.

9. Birthplace _____

(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

12. Name _____

13. Birthplace _____

(City, town, or county) (State or foreign country)

14. Maiden name _____

(City, town, or county) (State or foreign country)

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal)

(Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 11/28/40 (b) M. M. Brown
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____ (If outside city or town limits write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

20. DATE OF DEATH: Month Nov. Day 28 Year 40
hour _____ minute _____ M.

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

Immediate cause of death Coronary Thrombosis

Coronary Sclerosis

Due to premature due to anemia
due to circulatory failure

Due to following drop in blood pressure -
renal nephritis -

Other conditions chronic hypotension
(Include pregnancy within 3 months of death)

Major findings: terminal uraemia

Of operations _____

Of autopsy 94 B

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 _____ (M. D. or other) _____

Address _____ Date signed _____

SUPPLEMENTARY

PHYSICIAN

Underline the cause to which death should be charged statistically.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

HOWLIT MOORE

37942