

No. 2
4-13-40
3-17-39
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ED JAN 8 1941

Registration District No. **399**

Primary Registration District No. **1002**

Registrar's No. **4680**

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
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 Mo. & 13 days
(Specify whether years, months or days)

In this community _____
years, months or days

3. (a) PRINT FULL NAME WILLIAM E. HITCHENS

3. (b) If veteran, name war No

3. (c) Social Security No. No

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 March 1940
(Month) (Day) (Year)

8. AGE:			If less than one day
Years	Months	Days	
	<u>8</u>	<u>9</u>	hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name Lonzo Hitchens

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

14. Maiden name Bessie Hoslia

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

16. (a) Informant Lonzo Hitchens

(b) Address 920 Cambridge

17. (a) Burial (b) Date thereof 12-1-40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Green Lawn

18. (a) Signature of funeral director John P. Shell

(b) Address 6606 Indap Ave

19. (a) 12-9-40 (b) M. M. 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. 920 Cambridge
(If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 8th
year 1940 hour 8 minute 10 P. M.

21. I hereby certify that I attended the deceased from 10-25-40, 19____, to 12-8-40, 19____;
that I last saw him alive on 12-8-40, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death
Staphylococic Septicemia- Confluent
Bronchopneumonia

Due to _____

Due to _____

Other conditions Brain abscess; Parenchymatous degeneration of liver
(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 Wm. R. Stone (M. D. or other) _____
Address Med. Dir. K. Y. 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, fact should be so stated above.