

JAN 8 1941
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:
K.C. General Hospital No. 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 Mo. & 7 days
(Specify whether
In this community 30 years
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")
6221 E. 16th St. Terrace
(d) Street No. (If rural, give location)
(e) If foreign born, how long in U. S. A? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. 14th day.
year 1940 hour 8 minute 45 P. M.

21. I hereby certify that I attended the deceased from
11-7-40, 19 to 12-14-40, 19
that I last saw him alive on 12-14-40
and that death occurred on the date and hour stated above.

Immediate cause of death
Ascending pyelonephritis and
Prostatic abscess

Due to _____
Due to _____

Other conditions
(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)
_____ (Means of injury)

23. Signature Wiley R. Thorne (M. D. or other) _____
Address Med. Dir. K.C. Gen. Hospital Date signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

8. (a) PRINT FULL NAME ROBERT EDCLIE McDOWELL
8. (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 Married
6. (b) Name of husband or wife Mary McDowell 6. (c) Age of husband or wife if alive 68 years
7. Birth date of deceased May 8 1866
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
74 7 6 _____ hr. _____ min.

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

10. Usual occupation Laborer

11. Industry or business _____

MOTHER FATHER { 12. Name Don't know

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

14. Maiden name Don't know

15. Birthplace Don't know
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Mary McDowell

(b) Address 6221 East 16th Terrace

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

(c) Place: burial or cremation Mt. Moriah

18. (a) Signature of funeral director Freeman Mortuary

(b) Address 104 West 42nd Street

19. (a) 12-17-40 (b) M. M. Brown
(Date received local registrar) (Registrar's signature)

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 W. Chiles

Licensed Embalmer No. 2473

P. O. Address 707 N. 1st St.

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.