

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

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

Registration District No. 399

Primary Registration District No. 1002

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: Municipal The Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 3 yrs 2 Mos 14 da
(Specify whether years, months or days) 25 yrs

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. 2604 E 36 APT 7
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years

3. (a) PRINT FULL NAME William Mankin

3. (b) If veteran, name war no 3. (c) Social Security No. 495-10-5895

4. Sex Male 5. Color or race white 6. (a) Single, widowed, married, divorced M
6. (b) Name of husband or wife Cora Mankin 6. (c) Age of husband or wife if alive 45 years
7. Birth date of deceased Sept 18 1883
(Month) (Day) (Year)

8. AGE: Years 57 Months 3 Days 1 If less than one day hr. _____ min. _____

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

10. Usual occupation Street car Operator

11. Industry or business n

MOTHER FATHER { 12. Name W. C. Mankin
13. Birthplace Mo
(City, town, or county) (State or foreign country)
14. Maiden name Sally Garrison
(City, town, or county) (State or foreign country)
15. Birthplace MO
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Hesp Records
(b) Address Leads Station

17. (a) burial (b) Date thereof Nov 21 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mr Washington

18. (a) Signature of funeral director Ray Henderson

(b) Address 12-20-40 6 mo

19. (a) 12/20/40 (b) M M Brown
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 19, 1940
year 1940 hour 6 minute 10 P. M.

21. I hereby certify that I attended the deceased from 10-5-37, 19____, to 12-19-40, 19____;
that I last saw him alive on 12-19-40, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death Pul Tbc Duration _____

Due to _____
Due to 22
20

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? 361
While at work? _____ (Specify type of place) (e) Means of injury _____

28. Signature Dr. Hye Mankin (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

Henry E. Anderson

Licensed Embalmer No.

3657

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.