

MO JAN 8 1949
Registration District No. _____

Primary Registration District No. 1002

State File No. _____

4910

Registrar's No. _____

1. PLACE OF DEATH:
(a) County Jackson
(b) City or town Kansas City
(c) Name of hospital or institution: General Hospital #2
(d) Length of stay: In hospital or institution 12-22-40-12-25-40
In this community 40 years

3. (a) PRINT FULL NAME Clarence Hall
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 Single

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

8. AGE: about 40 Years Months Days If less than one day
Unknown hr. min.

9. Birthplace Brookfield Mo.

10. Usual occupation unemployed

MOTHER FATHER
11. Industry or business 9
12. Name Unknown
13. Birthplace Unknown
14. Maiden name Unknown
15. Birthplace Unknown

16. (a) Informant's own signature Record Clerk
(b) Address Gen. Hosp. #2

17. (a) Removal (b) Date thereof 12-26-1940
(c) Place: burial or cremation Marceline Mo.

18. (a) Signature of funeral director James M. C. Coy
(b) Address 1513 Trobat

19. (a) 12-26-40 (b) M. M. Kerobe
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo. (b) County Jackson
(c) City or town Kansas City
(d) Street No. 917 E. 14th St.
(e) If foreign born, how long in U. S. A. _____ years

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month 12 day 25
year 40 hour 4 minute P. M.
21. I hereby certify that I attended the deceased from 12-22- 19 40 to 12-25- 19 40
that I last saw him alive on 12-25- 19 40
and that death occurred on the date and hour stated above.

Immediate cause of death Broncho Pneumonia
Due to Arteriosclerosis
Due to _____

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

PHYSICIAN
Major findings: _____
Of operations _____
Of autopsy _____

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? _____
(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 G. O. L... (M. D. or other) _____
Address Gen. Hosp #2 Date signed 12-26-

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.

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

B. L. Graham

Licensed Embalmer No.

2540

P. O. Address

2208 Vine 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.