

JAN 8 1941 399

Registration District No. \_\_\_\_\_

Primary Registration District No. \_\_\_\_\_

Registrar's No. **4999**

1. PLACE OF DEATH:

(a) County. **JACKSON**  
(b) City or town. **KANSAS CITY MISSOURI**  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: **ST LUKES HOSPITAL**  
(If not in hospital or institution, write street name and location)  
(d) Length of stay: In hospital or institution **EIGHTEEN DAYS**  
(Specify whether  
In this community **Unknown**  
years, months or days)

3. (a) PRINT FULL NAME **GEORGE SEDGWICK**

3. (b) If veteran, name war **No** 8. (c) Social Security No. **No**

4. Sex **MALE** 5. Color or race **WHITE** 6. (a) Single, widowed, married, divorced **DIVORCED**  
6. (b) Name of husband or wife **ETHEL HIGGINS** 6. (c) Age of husband or wife if alive **--** years  
7. Birth date of deceased **March 3rd 1888**  
(Month) (Day) (Year)

8. AGE: Years **52** Months **9** Days **28** If less than one day hr. min.

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

10. Usual occupation **None**

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name **FRANK F. SEDGWICK** ✓  
13. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)

MOTHER FATHER { 14. Maiden name **MAY BELLE CRAIG**  
15. Birthplace **ST LOUIS MISSOURI** (City, town, or county) (State or foreign country)

16. (a) Informant **Ethel Higgins.**  
(b) Address **4229 Olive**

17. (a) **BURIAL** (Burial, cremation, or removal) (b) Date thereof **12/31/40**  
(Month) (Day) (Year)  
(c) Place: burial or cremation **ST MARYS CEMETRY**

18. (a) Signature of funeral director **MELLODY MCGILLEY**  
(b) Address **Kansas city Missouri**

19. (a) **12-30-40** (Date received local registrar) (b) **M. M. Crowe** (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **MISSOURI** (b) County **JACKSON**  
(c) City or town **KANSAS CITY MISSOURI**  
(If outside city or town limits, write "RURAL")  
(d) Street No. **3241 PASEO**  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. ? \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **December** day **29**  
year **1940** hour **12** minute **35** A. M.

21. I hereby certify that I attended the deceased from **Dec 5**, 19**40** to **Dec 29**, 19**40**,  
that I last saw him alive on **Dec 28**, 19**40**,  
and that death occurred on the date and hour stated above.

Immediate cause of death **Meloma Sarcoma Liver** Duration **2 mo.**

Due to **Meloma Sarcoma R. eye** **1 mo.**

Due to **4/2**

Other conditions (Include pregnancy within 3 months of death)

Major findings: **Meloma Sarcoma** Of operations. **Meloma Sarcoma** Of autopsy. **Meloma Sarcoma** 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? \_\_\_\_\_

While at work \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature **W. Parsons** (M. D. or other) \_\_\_\_\_  
Address **Playa Med Bldg** Date signed **12-20-40**

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

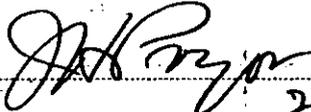
**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by 267

....., Registered Apprentice No. ....

working under my personal supervision.

Signed.....

  
.....  
Licensed Embalmer No. 2999

P. O. Address..... KS

**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.**

Registration District No. 399

Primary Registration District No. 1002

1. PLACE OF DEATH:

(a) County Jackson mo  
(b) City or town K.C.  
(If outside city or town limits, write "RURAL" and name of township)  
(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 \_\_\_\_\_ (Specify whether  
In this community \_\_\_\_\_  
years, months or days)

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) Citizen of foreign country \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME

Geo Sedgwick

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 Wid

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 52

Months 9

Days 26

If less than one day \_\_\_\_\_ hr \_\_\_\_\_ min.

9. Birthplace \_\_\_\_\_

(City, town, or county)

(State or foreign country)

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name \_\_\_\_\_

13. Birthplace \_\_\_\_\_

(City, town, or county)

(State or foreign country)

14. Maiden name \_\_\_\_\_

15. Birthplace \_\_\_\_\_

(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) \_\_\_\_\_

12/30/40

(b) \_\_\_\_\_

M. M. Crowe

(Date received local registrar)

(Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: month Dec day 29  
year \_\_\_\_\_ hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_; that last saw h. \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above.  
Immediate cause of death \_\_\_\_\_

Duration

Due to \_\_\_\_\_

Due to \_\_\_\_\_

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? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature U. Parsons (M. D. or other)  
Address Blairwood Bldg Date signed \_\_\_\_\_

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

SUPPLEMENTARY

S-41606