

JAN 8 1941 399

1002

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

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

Registrar's No. 5017

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:  
General Hospital #2  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 12-22-40-12-28-40  
(Specify whether)  
 In this community 16 years.  
years, months or days

3. (a) PRINT FULL NAME John Howe

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

4. Sex Male 5. Color or race Negro 6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Unknown 6. (c) Age of husband or wife if alive — years

7. Birth date of deceased 7 12 1864  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>76</u>	<u>5</u>	<u>16</u>	hr. <u>—</u> min. <u>—</u>

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

10. Usual occupation Unemployed.

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

MOTHER FATHER  
 { 12. Name Unknown  
 { 13. Birthplace Unknown  
(City, town, or county) (State or foreign country)  
 { 14. Maiden name Unknown  
 { 15. Birthplace Unknown  
(City, town, or county) (State or foreign country)

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

17. (a) Removal (b) Date thereof 12-31-40  
(Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation Bedford, Iowa

18. (a) Signature of funeral director West, Appleton & Jones  
 (b) Address 1905 Vine St.

19. (a) 1231-40 (b) M. M. Crowe  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Jackson  
 (c) City or town Kansas City  
(If outside city or town limits, write "RURAL")  
 (d) Street No. 2200 Vine St.  
(If rural, give location)  
 (e) If foreign born, how long in U. S. A. — years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 12 day 28  
 year 40 hour 2 minute 15 P.M.

21. I hereby certify that I attended the deceased from 12-28-40 to 12-28-40,  
 that I last saw him alive on 12-28-40 and that death occurred on the date and hour stated above.

Immediate cause of death Uremia, Bronchopneumonia.

Due to Septic peritonitis, Heart Disease - Chronic Nephritis

Due to 131

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

Major findings: —  
 Of operations —  
 Of autopsy —

Duration  
 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) (or means of injury)

23. Signature [Signature] (M. D. or other) \_\_\_\_\_  
 Address 26 Mo Date signed \_\_\_\_\_

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

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**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.....

*E. J. West*

Licensed Embalmer No. 2710

P. O. Address St. Louis, MO.

**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.**