

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:
K.C. General Hospital No. 1 0
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **1 day**
(Specify whether)

In this community **Unknown**
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")

(d) Street No. **705 Topping**
(If rural, give location)

(e) If foreign born, how long in U. S. A. _____ years.

3. (a) PRINT FULL NAME **JOHN ROGERS Rackwell**

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

4. Sex **Male** 5. Color or race **W** 6. (a) Single, widowed, married, divorced **M**

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

7. Birth date of deceased **April 17 1875**
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	65	9	11	hr. min.

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

10. Usual occupation **Drayman**

11. Industry or business _____

12. Name **Valley Rackwell**

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

14. Maiden name **Mary Maden**

15. Birthplace **Ohio**
(City, town, or county) (State or foreign country)

16. (a) Informant **Record Clerk**

(b) Address **U.C. Gen. Hospt**

17. **Removal** (b) Date thereof **1-29-47**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Marionville, Kansas**

18. (a) Signature of funeral director **Walter J. ...**

(b) Address **Marionville, Kansas**

19. (a) **Jan 29 1947** (b) **M. M. Crowe**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Jan.** day **28th**
year **1941** hour **10:00 P.** mid. M.

21. I hereby certify that I attended the deceased from **1-27-41**, 19____, to **1-28-41**, 19____;
that I last saw h. **im** alive on **1-28-41**, 19____,
and that death occurred on the date and hour stated above.

Immediate cause of death **Cardiac decompensation**

Due to **95C**

Due to _____

Other conditions **95C**
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____

Of autopsy **None**

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

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?
(Specify type of place)

While at work? _____ (e) Means of injury _____

23. Signature **Dr. W. R. Shaw** (M. D. or other) **D.**

Address **Med. Dir. A.C. Gen. Hospital** Date signed _____

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

48
3
8

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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.....

Licensed Embalmer No.....

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, fact should be so stated above.