

STANDARD CERTIFICATE OF DEATH

State File No. 13497

Registrar's No. 1478

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
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **5 days**
(Specify whether
In this community **12 yrs**
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. **105 West 39th St.**
(If rural, give location)
(e) Citizen of foreign country? **0** (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME **ARTHUR HUNTER**

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

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

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

7. Birth date of deceased **Feb 6 1913**
(Month) (Day) (Year)

8. AGE: Years **28** Months **2** Days **7** If less than one day hr. min.

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

10. Usual occupation **Baker**

11. Industry or business _____

12. Name **J. H. Hunter**

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

14. Maiden name **Daisy Mumford**

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

16. (a) Informant **Mildred Hunter**

(b) Address **105 West 39th St. K.C. Mo**

17. (a) **Removal** (b) Date thereof **4/14/41**
(Burial, cremation, or removal) (Month) (Day) (Year)

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

18. (a) Signature of funeral director **Ed. J. Mumford**

(b) Address **Kansas City, Kansas**

19. (a) **Apr 14, 1941** (b) **M. M. Crow**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **April** day **13th**
year **1941** hour **10:00 P.M.** minute _____ M.

21. I hereby certify that I attended the deceased from **4-8-41** 19____ to **4-13-41** 19____
that I last saw him alive on **4-13-41** 19____
and that death occurred on the date and hour stated above.

Immediate cause of death: **Rheumatic heart disease with stenosis of mitral and aortic valves**

Due to _____

Due to _____

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

Major findings: _____
Of operations _____

Of autopsy **See above**

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? _____

(Specify type of place) _____ While at work (e) Means of injury **0**

23. Signature **Dr. J. P. Shon** (M. D. or other) **0**

Address **K.C. Mo** Date signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

838

#5

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 D Ross Blanford
Licensed Embalmer No. 4015
P. O. Address 41 1/2 State Line

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.