

STANDARD CERTIFICATE OF DEATH

Registration District No. _____ Primary Registration District No. _____

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 4-17-41-4-19-41
 (Specify whether
 In this community 40 years
 years, months or days)

3. (a) PRINT FULL NAME William Turner
 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
 (Month) (Day) (Year)

8. AGE: Years 72 Months _____ Days _____ If less than one day _____ hr. _____ min.

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

10. Usual occupation Unemployed

11. Industry or business Unk

12. Name _____ 9

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

14. Maiden name _____ 9

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

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

17. (a) Burial (b) Date there Apr 28-41
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Funeral Home

18. (a) Signature of funeral director James M. Crow
 (b) Address 17107 E. 10th
 19. (a) Apr 26 1941 (b) M. M. Crow
 (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. 1506 E. 11th Street
 (If rural, give location)
 (e) If foreign born, how long in U. S. A.? 1 years.

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month 4 day 19
 year 41 hour 2 minute 20 P. M.

21. I hereby certify that I attended the deceased from 4-17-, 1941 to 4-19-, 1941;
 that I last saw him alive on 4-19-, 1941;
 and that death occurred on the date and hour stated above.

Immediate cause of death Congestive Heart Failure

Due to Arteriosclerotic Heart Disease

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

Major findings: Of operations _____
 Of autopsy Above Mentioned

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. J. Purman (M. D. or other) _____
 Address Gen. Hosp. #2 Date signed 4-21-41

Duration _____
 PHYSICIAN _____
 Underline the cause to which death should be charged statistically.

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. ~~3877~~
working under my personal supervision.

Signed.....

Fannie L Meek

Licensed Embalmer No. *3818*

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, above space should be left blank.