

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  
In this community unk 0 (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

Missouri Jackson 042  
(a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
(c) City or town Kansas City  
(If outside city or town limits, write "RURAL")  
(d) Street No. Portland Hotel  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_ 0

3. (a) PRINT FULL NAME George B. Yates

MEDICAL CERTIFICATION  
July 15th

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

20. DATE OF DEATH: Month \_\_\_\_\_ day \_\_\_\_\_  
year 1941 hour 7 minute 28 P. M.

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 alive \_\_\_\_\_ years  
7. Birth date of deceased June 27th 1886  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from 7-10-41 19\_\_\_\_ to 7-15-41 19\_\_\_\_;  
that I last saw him alive on 7-15-41 19\_\_\_\_  
and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_  
Ulcerative colitis with diarrhoea

8. AGE: Years Months Days If less than one day  
55 - 18 \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

9. Birthplace England 4  
(City, town, or county) (State or foreign country)

10. Usual occupation None

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

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

Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_

12. Name Alfred Yates 4  
13. Birthplace England (State or foreign country)

14. Maiden name Ellen Eatore  
15. Birthplace England (State or foreign country)

Of autopsy None  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

16. (a) Informant Record clerk  
(b) Address K.C. General Hospital

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? \_\_\_\_\_

17. (a) Burial (b) Date thereof 7-23-41  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_  
18. (a) Signature of funeral director Wm. H. [Signature]  
(b) Address City [Signature]

While at work \_\_\_\_\_ (Specify type of place) (c) Means of injury \_\_\_\_\_  
23. Signature Dr. R. Thora (M. D. or other) \_\_\_\_\_  
Address Med. Dir. K.C. Gen. Hospital, K. Mo.

19. (a) July 22, 1941 (b) M. M. Crowe  
(Date received local registrar) (Registrar's signature)

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

8/25/41

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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.....

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.**