

Registration District No. **279**

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 **R.C. General Hospital No. 1**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **3 Mo. & 19 days**
(Specify whether years, months or days) **0**
In this community **0**

3. (a) PRINT FULL NAME **ALBERT FRANKLIN DUNBAR**

3. (b) If veteran, name war _____ 3. (c) Social Security No. **486-26-1099**

4. Sex **Male** 5. Color or race **Wht** 6. (a) Single, widowed, married, divorced **Widowed**
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive **1886** years

7. Birth date of deceased **Sept 24** (Month) (Day) (Year) **1886**
8. AGE: Years **54** Months **10** Days **29** If less than one day hr. min.

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

10. Usual occupation _____
11. Industry, or business _____
MOTHER FATHER { 12. Name **Orvin G. Dunbar**
13. Birthplace **Paris** (City, town, or county) (State or foreign country)
14. Maiden name **Clara Dunn**
15. Birthplace **Lebanon** (City, town, or county) (State or foreign country)

16. (a) Informant **Lorna Davis**
(b) Address **3749 Brookings**
17. (a) **Nurse** (b) Date thereof **Aug 25 '41** (Month) (Day) (Year)
(Burial, cremation, or removal)
(c) Place: burial or cremation **buried**
18. (a) Signature of funeral director **Edwards**
(b) Address **605 E. Sparks**
19. (a) **8/25/41** (b) **M. M. Crowe** (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Jackson** **042**
(c) City or town **Kansas City**
(If outside city or town limits, write "RURAL")
(d) Street No. **3829 Garfield** (If rural, give location)
(e) Citizen of foreign country? **0** (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **August** day **23rd**
year **1941** hour **3** minute **05** P. M.

21. I hereby certify that I attended the deceased from **5-4-41**, 19____, to **8-23-41**, 19____;
that I last saw him alive on **8-23-41**, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death _____
TUBERCULOSIS OF LUNG;
DIABETES WITH DIABETIC GANGRENE
Due to _____
Due to **P.B.**

Other conditions (Include pregnancy within 8 months of death) _____
Major findings: Of operations _____
Of autopsy **None**
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) (c) Means of injury _____
23. Signature **Dwight R. Thom** (M. D. or other) **D**
Address **Med. Dir. K.C. Gen. Hospital** Date signed _____

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

2000

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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.