

FILED SEP 12 1941

Registration District No. 999

Primary Registration District No. 1002

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

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: N.C. Gen. Hosp. No. 1  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 8 days (Specify whether  
20 years years, months or days)

In this community \_\_\_\_\_

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 048

(c) City or town Kansas City  
(If outside city or town limits, write "RURAL")

(d) Street No. 813 West 21st St.  
(If rural, give location)

(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Santos Rangel

3. (b) If veteran, name war World War I

3. (c) Social Security No. 703-03-0511

4. Sex Male 4. Color or race Mexican

5. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Mrs. Josephine Rangel 6. (c) Age of husband or wife if alive 40 years

7. Birth date of deceased November 1, 1883  
(Month) (Day) (Year)

8. AGE: Years 57 Months 9 Days 22  
If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Mexico 3  
(City, town, or county) (State or foreign country)

10. Usual occupation Laborer

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

MOTHER FATHER { 12. Name Don't know

13. Birthplace Mexico 3  
(City, town, or county) (State or foreign country)

14. Maiden name Don't know

15. Birthplace Mexico 3  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Josephine Rangel

(b) Address 813 West 21st Street

17. (a) Burial (b) Date thereof 8-25-1941  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Maple Hill

18. (a) Signature of funeral director Freeman Mortuary

(b) Address 104 West 42nd Street

19. (a) 8/24/41 (b) M. M. Crow  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. day 23rd  
year 1941 hour 7 minute 15 A. M.

21. I hereby certify that I attended the deceased from 8-15-41 1941 to 8-23-41 1941;  
that I last saw him alive on 8-23-41 1941;  
and that death occurred on the date and hour stated above.

Immediate cause of death Bilateral bronchopneumonia;  
Due to Aortitis; encephalomalacia; Toxic Splenitis

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

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

Other conditions By phlebotomy  
(Include emergency 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? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury

23. Signature Dr. D. R. Thayer (M. D. or other)  
Address Med. Dir. K. C. Gen. Hospital 8-23-41

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..... *Clarence W. Chiles*  
Licensed Embalmer No. *3473*  
P. O. Address *Xero*

**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.**