No. 2
—1-4-41
5-17-39
PI X26390

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED OCT 15 1941

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 30515

Registration District No. 399 Primary Registration District No. 1002 Registrar's No. 3272

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: St. Joseph's Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 Day (Specify whether years, months or days)

In this community life

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. 5135 Walrond Avenue
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country --

3. (a) PRINT FULL NAME Michael Arthur Hale

3. (b) If veteran, name war No

3. (c) Social Security No. None

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 August 30 1941 (Month) (Day) (Year)

8. AGE: Years 0 Months 0 Days 1 If less than one day ---- hr. ---- min.

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

10. Usual occupation ------

11. Industry or business ------

MOTHER FATHER

12. Name Arthur B. Hale

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

14. Maiden name Lillian Senika

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

16. (a) Informant Arthur B. Hale

(b) Address 5135 Walrond Avenue

17. (a) Cremation (Burial, cremation, or removal) (b) Date thereof Sept. 1, 1941 (Month) (Day) (Year)

(c) Place: burial or cremation D. W. Newcomer's Sons

18. (a) Signature of funeral director D. W. Newcomer's Sons

(b) Address 1401 Brush Creek Blvd.

19. (a) 9/1/41 (Date received local registrar) (b) M. M. Crowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 30st year 1941 hour 6 minute 30 P.M.

21. I hereby certify that I attended the deceased from 8/29/41, 19__ to 8/30/41, 19__; that I last saw h. alive on 8/30/41, 19__; and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage — Duration 2 day.

Due to Birth trauma.

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy Cerebral Hemorrhage
Cerebral Hemorrhage

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? (Specify type of place)

While at work? (e) Means of injury

23. Signature J. H. Hinkle (M. D. or other) M.D.

Address 1103 Grand Date signed 9/1/41

361 (Licensed Embalmer's Statement on Reverse Side)

Dr. Joseph Webb
St. Joseph's Hos
By 10 a.m. mon

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 H. C. Newcomer Jr

Licensed Embalmer No. 4043

P. O. Address K. C. Mo.

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.