

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 **1 day** (Specify whether years, months or days)
In this community **1 day**

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. **3501 Euclid**
(If rural, give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME **Furrell infant**

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

4. Sex **Male** 5. Color or race **W** 6. (a) Single, widowed, married, divorced **single**

6. (b) Name of husband or wife **XXX** 6. (c) Age of husband or wife if alive **XXX** years

7. Birth date of deceased **September 8, 1941**
(Month) (Day) (Year)

8. AGE: Years **XXX** Months **XX** Days **XX** If less than one day **14 hr. 5 min.**

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

10. Usual occupation **XXX**

11. Industry or business **XX**

12. Name **Roy Furrell**

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

14. Maiden name **Shirley Gaston**

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

16. (a) Informant **Record Clerk**

(b) Address **K. C. General Hospital**

17. (a) **burial** (b) Date thereof **Sept-16-41**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Med. Dir. K.C. Gen. Hospital**

18. (a) Signature of funeral director **Wm. A. Stoney**
(b) Address **City, Mo.**

19. (a) **9/15/41** (b) **M. M. Crowe**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Sept.** day **9th**
year **1941** hour **11** minute **55** A.M. M.

21. I hereby certify that I attended the deceased from **9-8-41** to **9-9-41**
that I last saw him alive on **9-9-41**
and that death occurred on the date and hour stated above.

Immediate cause of death **subarachnoid hemorrhage**

Due to

Due to

Other conditions (include pregnancy within 8 months of death)

Major findings: Of operations **160**

Of autopsy

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) (e) Means of injury
23. Signature **Wm. R. Horn** (M. D. or other)
Address **Med. Dir. K.C. Gen. Hospital** Date signed

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

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.