

FILED FEB 11 1942  
399

Registration District No. ....

Primary Registration District No. 1002

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

1. PLACE OF DEATH:

Jackson  
(a) County  
(b) City or town Kansas City  
(c) Name of hospital or institution K.C. General Hospital  
(d) Length of stay: In hospital or institution 1 day  
In this community Unknown

2. USUAL RESIDENCE OF DECEASED:

Missouri Jackson  
(a) State (b) County  
(c) City or town Kansas City  
(d) Street No. Central Hotel, 12th & Central  
(e) Citizen of foreign country? (Yes or No)

3. (a) PRINT FULL NAME MINNIE CHEW

3. (b) If veteran, name war None 3. (c) Social Security No. None

4. Sex Female / 5. Color or race White 6. (a) Single, widowed, married, divorced, Widowed  
6. (b) Name of husband or wife 6. (c) Age of husband or wife if alive years

7. Birth date of deceased Unknown 1887  
(Month) (Day) (Year)

8. AGE: Years 54 Months Days If less than one day  
hr. min.

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

10. Usual occupation None

11. Industry or business

MOTHER FATHER { 12. Name Unknown  
13. Birthplace Unknown  
14. Maiden name Unknown  
15. Birthplace Unknown

16. (a) Informant Record Clerk  
(b) Address K.C. General Hosp. #1

17. (a) Removal (b) Date thereof 1 24 42  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Russelville, Arkansas  
Weilert Funeral Home

18. (a) Signature of funeral director  
(b) Address 2332 Monitor Place, K.C., Mo.

19. (a) 1-24-42 (b) M. M. Crowe  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. 23rd  
year 1942 hour 11:00 A.M. minute M.

21. I hereby certify that I attended the deceased from 1-22-42 to 1-23-42  
that I last saw him alive on 1-23-42  
and that death occurred on the date and hour stated above.

Immediate cause of death Lobar Pneumonia

Due to 108

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations Of autopsy

Duration  
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?  
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

23. Signature of physician M. M. Crowe (M. D. or other)  
Address Med. Dir. K.C. Gen. Hospital Date signed

**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.....

*Blaine E. Weiler*

Licensed Embalmer No.....

*4075*

P. O. Address.....

*2332 Monitor Ct*

**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.**