

Registration District No. **399**

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: **K.C. General Hospital No. 1 E**
(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) **4 mo's**

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

3. (a) PRINT FULL NAME **HAROLD WILHITE, Jr.**

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

4. Sex **M** 5. Color or race **w** 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 **oct 10 1941**
(Month) (Day) (Year)

8. AGE: Years **2** Months **17** If less than one day hr. _____ min. _____

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

10. Usual occupation **none**

MOTHER FATHER

11. Industry or business _____

12. Name **Harold High Wilhite**

13. Birthplace **Levard, Mo**
(City, town, or county) (State or foreign country)

14. Maiden name **Pauline Wynne**

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

16. (a) Informant **Harold High Wilhite**

(b) Address **622 Corrington**

17. (a) **Burial** (b) Date thereof **Jan 30-1942**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Funeral Home**

18. (a) Signature of funeral director **Sheil Funeral Home**

(b) Address **19 Cass St, Mo**

19. (a) **1/28/42** (b) **M. M. Crow**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Jan.** day **27th**
year **1942** hour **4** minute **45** P. M.

21. I hereby certify that I attended the deceased from **1-26-42** 19____ to **1-27-42** 19____;
that I last saw him alive on **1-27-42** 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death: **Bronchopneumonia**

Due to _____

Due to _____

Other conditions (Include pregnancy 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? _____

(Specify type of place) _____ While at work _____

(Specify type of place) _____ Means of injury _____

23. Signature **Drury R. Thom** (M. D. or other) _____

Address **Med. Dir. K.C. Gen. Hospital** Date signed _____

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.....

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.