

FILED MAY 21 1942
Registration District No. _____

Primary Registration District No. 1002

Registrar's No. 1915

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:
4707 1/2 Euclid
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether _____)

In this community _____ years, months or days 25 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 48

(c) City or town Kansas City 3
(If outside city or town limits, write "RURAL")

(d) Street No. 6006 Euclid
(If rural, give location)

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

If yes, name country _____

3. (a) PRINT FULL NAME Jack Agharian

(b) If veteran, name war _____

(c) Social Security No. 447-03-8246

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 5 day 14 - year 42

year _____ hour _____ minute 6:05 P. M.

4. Sex Male

5. Color or race White

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

6. (b) Name of husband or wife Evelyn Agharian

6. (c) Age of husband or wife if alive 35 years

7. Birth date of deceased: July (Month) 1 (Day) 1894 (Year)

21. I hereby certify that I attended the deceased from _____ 19____ to _____ 19____; that I last saw him/her alive on _____ 19____; and that death occurred on the date and hour stated above.

Immediate cause of death _____

8. AGE: Years 47 Months 10 Days 22 hr. _____ min. _____

Duration _____

Due to Cornary Occlusion

Due to Cornary Atherosclerosis

Other conditions (Include pregnancy within 3 months of death) 94a

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

10. Usual occupation Reg. Washer

11. Industry or business Home Reg. Cleaning Co.

12. Name Agharian

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

14. Maiden name Antonyan

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

Major findings: Of operations _____

Of autopsy _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

16. (a) Informant Evelyn Agharian

(b) Address 6006 Euclid

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/16/42 (Month) (Day) (Year)

(c) Place: burial or cremation Green Lawn Cem

18. (a) Signature of funeral director Snaw Meyer

(b) Address 2315 Euclid

19. (a) 5-16-42 (Date received local registrar) (b) M. M. Crowe (Registrar's signature)

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 [Signature] (M. D. or other) _____

Address [Signature] Date signed _____

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

MOTHER FATHER

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.....

Ray E. Snow
Licensed Embalmer No. *2560*

P. O. Address..... *K. E. M.*

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.