

FILED JUN 6 1942

State File No. _____

Registration District No. 999

Primary Registration District No. 1002

Registrar's No. 2124

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

1. PLACE OF DEATH

(a) County Jackson

(b) City or town Kansas City

(c) Name of hospital or institution: 1220 - West 21st 1
(If not in hospital or institution, write street number or location)

(d) Length of stay: about 25 yrs. (Specify whether years, months or days)

3. (a) PRINT FULL NAME Ray Michael

3. (b) If veteran, name war no

3. (c) Social Security No. none

4. Sex M-O

5. Color or race W.

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

6. (b) Name of husband or wife Martha

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

7. Birth date of deceased Apr 17 1889
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>53</u>	<u>1</u>	<u>11</u>	hr. _____ min. _____

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

10. Usual occupation Nursey

11. Industry or business Self

12. Name John Michael

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

14. Maiden name Ida Chance

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

16. (a) Informant Helen Hawley

(b) Address 1662 Jefferson

17. (a) Burial (b) Date thereof 6-1-42
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Maple Hill Cem

18. (a) Signature of funeral director Daniel Bruce

(b) Address 644 Kans. Gun. & C. Kansas

19. (a) May 31 1942 (b) M. M. Brown
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Jackson

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

(d) Street No. 1220 W. 21st
(If rural, give location)

(e) Citizen of foreign country? — (Yes or No)
If yes, name country —

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 28
year 1942 hour 6 minute 45 P. M.

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

Immediate cause of death Hypertensive myocarditis

Due to 124 B

Other conditions Fatty Liver - liver
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____
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 3

23. Signature Russell W. Brown (M. D. or other)
Address Kans. Date signed _____

2041

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.....

Harry C Bugman....., Registered Apprentice No. *2041*
working under my personal supervision

Signed *Harry C Bugman*
Licensed Embalmer No. *2041*
P. O. Address *4306 Mill Creek*

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

State File No.

Registration District No. Primary Registration District No. Registrar's No. 2124

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: _____
(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)

3. (a) PRINT FULL NAME Roy Michael

3. (b) If veteran, name war _____

3. (c) Social Security No. 487-16-8229

4. Sex _____

5. Color or race _____

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

6. (b) Name of husband or wife _____

6. (c) Age of husband, or wife, if alive _____ year

7. Birth date of deceased _____
(Month) (Day) (Year)

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

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

10. Usual occupation _____

11. Industry or business _____

12. Name _____

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

14. Maiden name _____

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

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) Dr. In Crow
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____

(c) City or town _____
(If outside city or town limits write "RURAL")

(d) Street No. _____
(If rural, give location)

(e) If foreign born, how long in U. S. A.? _____ years.

20. DATE OF DEATH: _____ month _____ day _____ year _____ hour _____ minute _____ M.

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

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: _____
Of operations _____

Of autopsy _____

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 _____ (M. D. or other) _____
Address _____ Date signed _____

SUPPLEMENTAL

Duration _____

PHYSICIAN

Underline the cause to which death should be charged statistically.

1942
S-17079