

FILED JUL 17 1942

Registration District No. 399

Primary Registration District No. 1002

State File No. _____
Registrar's No. 2634

1. PLACE OF DEATH

(a) County Kansas City

(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: General #2 Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution about 30 min.
(Specify whether years, months or days)

In this community few minutes
(Specify whether years, months or days)

3. (a) PRINT FULL NAME RICHARD DAWSON

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

4. Sex Male 5. Color or race Negro 6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife unk 6. (c) Age of husband or wife if alive _____ years

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

8. AGE: Years (about) 61 Months _____ Days _____ If less than one day _____ hr. _____ min.

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

10. Usual occupation Laborer

11. Industry or business unknown

12. Name Sam Dawson

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

14. Maiden name Smith

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

16. (a) Informant General Hospital Record

(b) Address H. C. Mrs July 10-1942

17. (a) burial (b) Date thereof July 10-1942
(Month) (Day) (Year)

(c) Place: burial or cremation Shawnee, Okla
Brady & Brown

18. (a) Signature of funeral director 1708 Tracy

(b) Address _____

19. (a) 7-10-42 (b) M. M. Browne
(Date received local registrar) (Registrar's signature)

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. 1125 Garfield
(If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 7 day 9 year 42 hour 9:35 minute PM M.

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

Immediate cause of death Acute myocardial failure; Hypertensive heart disease.

Due to _____ -9315

Due to _____

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

Major findings: Of operations _____
Of autopsy See above

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? _____
(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 _____ (e) Means of injury _____

23. Signature [Signature] 3 7/10/42
Address _____ 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.