

STANDARD CERTIFICATE OF DEATH

State File No. _____

Registrar's No. **2411**

Registration District No. **399**

Primary Registration District No. **1002**

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:
Kansas City General Hospital No. 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **4 days**
In this community **Unknown** (Specify whether years, months or days)

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. **635 Troost Avenue**
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country **0**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **June** day **19th**
year **1942** hour **4** minute **30 A.M.**

21. I hereby certify that I attended the deceased from **6-15-42**, 19____, to **6-19-42**, 19____;
that I last saw him **alive** on **6-19-42**, 19____,
and that death occurred on the date and hour stated above.

Immediate cause of death:
**Post operative cholecystomy for
Cholelithiasis; Acute circulatory
Due to Failure; Chronic nephritis**

Due to **126**

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? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature **Wm. R. Thorne** (M. D. or other)
Address **Med. Dir. K. Gen. Hospital 6-18-42**

3. (a) PRINT FULL NAME **Minnie Reed**

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 **Unknown** 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased **Unknown 1878 1863**
(Month) (Day) (Year)

8. AGE: Years **79** 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 **None**

12. Name **Unknown**

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

14. Maiden name **Unknown**

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

16. (a) Informant **Mr. E/ G. Dennison**
(b) Address **Lake Tapawingo, Mo.**

17. (a) **Cremation** (b) Date thereof **June 22, 1942**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **D.W. Newcomer (s. Sons)**

18. (a) Signature of funeral director **D.W. Newcomer**

(b) Address **1401 Brush Creek Blvd**

19. (a) **6-22-42** (b) **M. M. Browe**
(Date received local registrar) (Registrar's signature)

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

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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 Emile M. Colburn
Licensed Embalmer No. 3506
P. O. Address fc no

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.