

FILED AUG 17 1942

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 2976

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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. 10  
(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)

In this community mark

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. 548 1/2 Main St. (If rural, give location)

(e) Citizen of foreign country? 0 (Yes or No)  
If yes, name country 0

3. (a) PRINT FULL NAME CHARLES CANNON

3. (b) If veteran, name war no

3. (c) Social Security No. none

4. Sex M. 5. Color or race W.

6. (a) Single, widowed, married, divorced 9 No record

6. (b) Name of husband or wife mark

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

7. Birth date of deceased No record  
(Month) (Day) (Year)

8. AGE: Years about 72 Months No record Days 9 If less than one day hr. min.

9. Birthplace No record  
(City, town, or county) (State or foreign country)

10. Usual occupation No record

11. Industry or business

12. Name No record

13. Birthplace No record  
(City, town, or county) (State or foreign country)

14. Maiden name No record

15. Birthplace No record  
(City, town, or county) (State or foreign country)

16. (a) Informant Record clerk

(b) Address K.C. General Hospital

17. (a) Burial (b) Date thereof 8-7-42  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Burial

18. (a) Signature of general registrar Mark A. Johnson

(b) Address City

19. (a) 8-7-42 (b) M. M. Crow  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 30th  
year 1942 hour 1 minute 12 A.M.

21. I hereby certify that I attended the deceased from 7-29-42 to 7-30-42

that I last saw him alive on 7-30-42

and that death occurred on the date and hour stated above.

Immediate cause of death Uremia, chronic; arteriosclerotic heart disease; hypertension

Due to 9315

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy None

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) (c) Means of injury

23. Signature Dr. R. Shore (M. D. or other)

Address Med. Dir. K.C. Gen. Hospital Date signed 7-31-42

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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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.....

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.**