

FILED AUG 17 1942

State File No.

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 2980

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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. 1
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 18 days
(Specify whether years, months or days)

In this community unk.

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. 515 East 9th St.
(If rural, give location)

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

3. (a) PRINT FULL NAME Roy Kintz

3. (b) If veteran, name war No record

3. (c) Social Security No. none

4. Sex M. Color or race W.

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

6. (b) Name of husband or wife No record

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

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

8. AGE: Years 63 Months Days If less than one day
hr. min.

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

10. Usual occupation No record

11. Industry or business ---

MOTHER FATHER { 12. Name No record

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 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 Funeral Home

18. (a) Signature of funeral director Wm. A. ...

(b) Address City

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 1st
year 1942 hour 2 minut 55 A.M.

21. I hereby certify that I attended the deceased from 7-14-42 19... to 8-1-42 19...
that I last saw him alive on 8-1-42 19...
and that death occurred on the date and hour stated above.

Immediate cause of death
Auricular Fibrillation

Due to 95a

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy None

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) (c) Means of injury

23. Signature Wm. R. Horn (M. D. or other) 0
Address Med. Dir. K.C. Gen. Hospital K.C. Mo. Date signed 8-6-42

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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.