

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 2981

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 4 days
(Specify whether years, months or days)

In this community 22 years

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. 702 Woodland
(If rural, give location)

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

3. (a) PRINT FULL NAME Robert A. Loucks

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

3. (c) Social Security No. No record

4. Sex M. Color or race W.

5. Color or race W.

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

6. (b) Name of husband or wife Frankie Louks

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

7. Birth date of deceased Nov. 7th, 1881
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>60</u>	<u>8</u>	<u>24</u>	hr. min.

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

10. Usual occupation None listed

11. Industry or business _____

MOTHER FATHER

12. Name Alva Loucks

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

14. Maiden name Louise Anderson

15. Birthplace Illinois
(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 Field St. Pl.

18. (a) Signature of funeral director Wanda Johnson

(b) Address City Mortician

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 31st
year 1942 hour 12 M. minute _____ M.

21. I hereby certify that I attended the deceased from 7-27-42, 19____, to 7-31-42, 19____;
that I last saw him alive on 7-31-42, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death Septicemia, infected knee

Due to n. m. o

Due to 2 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)

While at work? _____ Means of injury _____

23. Signature Drury R. Thom (M. D. or other) _____
Address Med. Dir. K. C. Gen. Hospital Date signed 8-6-42

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

48
3
8

48
3
8

341

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.