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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED OCT 5 1942

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

29614

State File No.

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 3567

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

(d) Length of stay: In hospital or institution 3 days (Specify whether years, months or days)

In this community unknown

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 48

(c) City or town Kansas City (If outside city or town limits, write "RURAL") 3

(d) Street No. 7611 Wornall Road (If rural, give location) 8

(e) Citizen of foreign country? (Yes or No) 0

If yes, name country

3. (a) PRINT FULL NAME James Whittaker

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

3. (c) Social Security No. none

4. Sex M. 0

5. Color or race W.

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

6. (b) Name of husband or wife ——

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

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

8. AGE: Years About 86 | Months | Days | If less than one day hr. min.

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

10. Usual occupation No record

11. Industry or business 9

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

MOTHER
14. Maiden name No record 9
15. Birthplace No record (City, town, or county) (State or foreign country)

16. (a) Informant Record Clerk

(b) Address K.C. Gen Hospt. 1

17. (a) State Asst. Board (Burial, cremation, or removal) (b) Date thereof 9-28-42 (Month) (Day) (Year)

(c) Place: burial or cremation K.C. Western Dental College

18. (a) Signature of funeral director Snow Mayhew

(b) Address 2315 Lawrence

19. (a) 9-28-42 (Date received local registrar) (b) M. M. Crowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 24th year 1942 hour minute M.

21. I hereby certify that I attended the deceased from 9-21-42, 19 to 9-24-42, 19; that I last saw him alive on 9-24-42, 19; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Arteriosclerotic heart disease with congestive heart failure	
Due to 93 D	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy None

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)

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 Henry R. Thom (M. D. or other)

Address Med. Dir. K.C. Gen. Hospital Date signed

(Licensed Embalmer's Statement on Reverse Side)

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 wit the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.