

Registration District No. **FILED JAN 18 1943**

Primary Registration District No. 1002

Registrar's No. 4981

1. PLACE OF DEATH:  
 Jackson  
 (a) County \_\_\_\_\_  
 (b) City or town Kansas City  
(If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution: General Hospital No. 20  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 12-7-42-12-22-42  
(Specify whether  
 In this community Unknown  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
 Missouri Jackson 48  
 (a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
 (c) City or town Kansas City  
(If outside city or town limits, write "RURAL")  
 (d) Street No. 1820 Grove  
(If rural, give location)  
 (e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
 If yes, name country \_\_\_\_\_ 0

3. (a) PRINT FULL NAME SAM TURNER

MEDICAL CERTIFICATION  
 20. DATE OF DEATH: Month December day 22  
 year 1942 hour 4 minute 00 a.m.

3. (b) If veteran, name war Frank 3. (c) Social Security No. unk

21. I hereby certify that I attended the deceased from December 7, 1942 to December 22, 1942, and that death occurred on the date and hour stated above.

4. Sex Male 5. Color or race Negro 6. (a) Single, widowed, married, divorced unk  
 6. (b) Name of husband or wife Unknown 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
 7. Birth date of deceased: July 17, 1874  
(Month) (Day) (Year)

Immediate cause of death: Hypertensive type heart disease with cardiac decompensation Duration \_\_\_\_\_

8. AGE: Years 68 Months 5 Days 5 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

Due to \_\_\_\_\_ 935  
 Due to \_\_\_\_\_

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

Other conditions: \_\_\_\_\_  
(Include pregnancy within 3 months of death)

10. Usual occupation: Unknown

Major findings: \_\_\_\_\_  
 Of operations \_\_\_\_\_  
 Of autopsy \_\_\_\_\_

11. Industry or business: \_\_\_\_\_

MOTHER FATHER {  
 12. Name: Unknown  
 13. Birthplace: Unknown 9  
(City, town, or county) (State or foreign country)  
 14. Maiden name: Unknown  
 15. Birthplace: Unknown 9  
(City, town, or county) (State or foreign country)

22. If death was due to external causes, fill in the following:

16. (a) Informant: Record Clerk

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_

(b) Address: General Hospital #2

(b) Date of occurrence \_\_\_\_\_

17. (a) Burial (b) Date thereof: \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)

(c) Place: burial or cremation: Field

(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

18. (a) Signature of funeral director: Wm. A. [Signature]

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

(b) Address: City [Signature]

23. Signature: [Signature] (M. D. or other)  
 Address: Gen. Hosp. #2 - 600 E. 22 Date signed 12-30-42

19. (a) 12/31/42 (b) M. H. Grove  
(Date received local registrar) (Registrar's signature)

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

2007 10 08 11:14

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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.**