

Registration District No. **149**

Primary Registration District No. **1002**

Registrar's No. **4912**

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

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town J.C.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
611 1/2 E 8th
(If not in hospital or institution, write street number or location)

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

In this community, unknown
(Specify whether years, months or days)

3. (a) PRINT FULL NAME CHARLES W WARD

3. (b) If veteran, name war Unknown 3. (c) Social Security No. none

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced Unknown

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

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

8. AGE: Years 75 Months Days If less than one day
hr. min.

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

10. Usual occupation.....

11. Industry or business.....

MOTHER FATHER

12. Name.....

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 Cover

(b) Address K. C. Mo.

17. (a) ~~Burial~~ Removal (b) Date thereof 12/30/42
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation North Hill Cem.

18. (a) Signature of funeral director Sebbeto's

(b) Address 901 E 5th

19. (a) 12-30-42 (b) M. M. Brown
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Jackson

(c) City or town K.C.
(If outside city or town limits, write "RURAL")

(d) Street No. 611 1/2 E 8th
(If rural, give location)

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

If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 12 day 26
year 42 hour 9:55 minute..... M.

21. I hereby certify that I attended the deceased from Brown to..... 19.....

that I last saw him..... alive on..... 19.....
and that death occurred on the date and hour stated above.

Immediate cause of death Arteriosclerotic heart disease

Due to.....

Due to..... 93 D

Other conditions.....
(Include pregnancy within 3 months of death)

Major findings:
Of operations.....

Of autopsy ruptured aorta

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?

While at work.....
(Specify type of place) Means of transport.....

23. Signature [Signature] (M. D. of op.) 3

Address [Signature] Date signed [Signature]

3105
Candler Clinical Hosp
Grubbs Ave

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 Ray E. Snow

Licensed Embalmer No. 2560

P. O. Address IL C MD

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.