

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 5 days (Specify whether
In this community 25 years
years, months or days)

3. (a) PRINT FULL NAME Ira Hall
3. (b) If veteran, No record name war
3. (c) Social Security No. none

4. Sex Male
5. Color or face White
6. (a) Single, widowed, married, divorced Divorced
6. (b) Name of husband or wife remarried
6. (c) Age of husband or wife if alive years
7. Birth date of deceased April 6th 1872
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>70</u>	<u>9</u>	<u>54</u> hr. min.

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

10. Usual occupation None

11. Industry or business

MOTHER FATHER {
12. Name Deceased
13. Birthplace no record 9
(City, town, or county) (State or foreign country)
14. Maiden name Deceased
15. Birthplace No record 9
(City, town, or county) (State or foreign country)

16. (a) Informant K.C. Gen. Hosp.

(b) Address K.C. Mo.

17. (a) Removal (b) Date thereof 1-14-43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Kirkmanville College of Podiatry

18. (a) Signature of funeral director W. S. Hart

(b) Address K.C. Mo.

19. (a) 1-13-43 (b) M. M. Coswell
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED: 48
(a) State Missouri (b) County Jackson
(c) City or town Kansas City
(If outside city or town limits, write "RURAL")
(d) Street No. Portland Hotel, 6th & Main
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country 0

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 10th
year 1943 hour 8 minute 50 A.M. M.

21. I hereby certify that I attended the deceased from 1-6-43, 19....., to 1-10-43, 19.....;
that I last saw him alive on 1-10-43, 19.....;
and that death occurred on the date and hour stated above.

Immediate cause of death Lobar pneumonia
Duration

Due to 108

Due to

Other conditions (Include pregnancy within 3 months of death)

PHYSICIAN
Major findings:
Of operations
Of autopsy None
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) (e) Means of injury

23. Signature Drury R. Thone (M. D. or other)

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

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.