

FILED FEB 10 1943

Registration District No. 1219

Primary Registration District No. 10.02

Registrar's No. 429

1. PLACE OF DEATH:

(a) County Jackson  
(b) City or town R. C.  
(c) Name of hospital or institution:  
2718 E 18th St 1  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution..... (Specify whether  
In this community unknown (Specify whether  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Jackson  
(c) City or town R. C. MO  
(If outside city or town limits, write "RURAL")  
(d) Street No. 2718 E 18th St  
(If rural, give location)  
(e) Citizen of foreign country?..... (Yes or No)  
If yes, name country.....

3. (a) PRINT FULL NAME

Sam Logan

3. (b) If veteran, name war.....

unknown

3. (c) Social Security number.....

unknown

4. Sex male

5. Color or race C. wh

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

9 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

Months

Days

If less than one day

about 70

hr. min.

9. Birthplace

(City, town, or county)

(State or foreign country) 9

10. Usual occupation

11. Industry or business

12. Name

Logan

13. Birthplace

(City, town, or county)

(State or foreign country) 9

14. Maiden name

15. Birthplace

(City, town, or county)

(State or foreign country) 9

16. (a) Informant

Coroner

(b) Address

R. C. MO

17. (a) removal (Burial, cremation, or removal)

(b) Date thereof Jan 29-43 (Month) (Day) (Year)

(c) Place: burial or cremation Maple Hill, R. C. MO

18. (a) Signature of funeral director J. Walton

(b) Address R. C. MO

19. (a) 1-27-43 (Date received local registrar)

(b) Dr. H. Browne (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 1 day 18 year 1943 hour 10:50 minute a. M.

21. I hereby certify that I attended the deceased from Coroner, 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.....

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

Major findings: Of operations.....

Of autopsy Inspection & history

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 Dr. H. Browne (M. D. or other) 3

Address R. C. MO Date signed 1/29/43

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

MOTHER FATHER

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

**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

*F. S. Walton*

Licensed Embalmer No. *2744*

P. O. Address

*K. C. Mo*

**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.**