

FILED JAN 30 1943

263

Registration District No. 199

Primary Registration District No. 1002

Registrar's No. _____

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: H.C. Convalescent Home 3200 Norledge
(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) 20 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Jackson
(c) City or town Kansas
(If outside city or town limits, write "RURAL")
(d) Street No. Gortz Hotel 417 E 10th St.
(If rural, give location) 0
(e) If foreign born, how long in U. S. A? _____ years.

3. (a) PRINT FULL NAME John Tremor Fe

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

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

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

7. Birth date of deceased Aug 15 1885
(Month) (Day) (Year)

8. AGE: Years 58 Months 85 Days 1 If less than one day _____ hr. _____ min.

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

10. Usual occupation Shoe maker

11. Industry or business _____

MOTHER FATHER { 12. Name Louis Tremor Fe

13. Birthplace Italy 5
(City, town, or county) (State or foreign country)

14. Maiden name Josephine Scudazzo

15. Birthplace Italy 5
(City, town, or county) (State or foreign country)

16. (a) Informant Dr Louis G. Tremor Fe

(b) Address 6600 Blue Ridge Blvd.

17. (a) Burial (b) Date thereof Jan 19 1943
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Floral Hill Cemetery

18. (a) Signature of funeral director Pussantino Bros

(b) Address 15. C. Mo

19. (a) 1-18-43 (b) M. M. Crowe
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan 16 day
year 1943 hour 6:50 minute 0 P. M.

21. I hereby certify that I attended the deceased from 1-12-43
_____, 19____, to 1-16-43
_____, 19____.

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

Immediate cause of death _____

Due to Cerebral thrombosis

Due to Right hemiplegia

Other conditions 850
(Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

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 J. H. ... (M. D. or vet.)
Address ... Date signed 1/16-43

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

4 20 1 3 73

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.....

Park G Rowe

Licensed Embalmer No. 2347

P. O. Address. 12, Cmo

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, above space should be left blank.