

FILED MAR 5 1943/49
Registration District No.

Primary Registration District No. **1002**

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 **1 Mo. & 21 ds.**
(Specify whether
In this community **0 years**
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Jackson**
(c) City or town **Kansas City**
(If outside city or town limits, write "RURAL")
(d) Street No. **24 East 3rd St.**
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country.....

3. (a) PRINT FULL NAME **Edmund Jensen**

3. (b) If veteran, name war **no** 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 **May 18 62**
(Month) (Day) (Year)

8. AGE: Years **1880** Months **9** Days **-** If less than one day hr. min.

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

10. Usual occupation **laborer**

11. Industry or business **same as usual**

12. Name.....

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

14. Maiden name.....

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

16. (a) Informant **General Hospital REC ma**

(b) Address **Kansas City mo**

17. (a) **Removal** (Burial, cremation, or removal) (b) Date thereof **2/8/43**
(Month) (Day) (Year)

(c) Place: burial or cremation **Omaha Neb.**

18. (a) Signature of funeral director **Snou Mayberry**

(b) Address **2315 Benning**

19. (a) **2-9-43** (Date received local registrar) (b) **M. M. Brown** (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Feb.** day **9th**
year **1943** hour **12** minute **37 A.M.**

21. I hereby certify that I attended the deceased from **12-19-43**, 19..... to **2-9-43**, 19.....
that I last saw him alive on **2-9-43**, 19.....
and that death occurred on the date and hour stated above.

Immediate cause of death.....
Fracture of right femur, accidental fall

Due to..... **181-2**

Due to..... **10**

Other conditions **Senility**
(Include pregnancy within 3 months of death)

Major findings:
Of operations.....

Of autopsy **None**

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

(a) Accident, suicide, or homicide (specify) **Acc 123**

(b) Date of occurrence **Dec 19 1943**

(c) Where did injury occur? **K.C. Jack mo**
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
Public Place
(Specify type of place)

While at work? **Fall**
(c) Means of injury

23. Signature **Dr. R. Thorsen** (M. D. or other)
Med. Dir. **K.C. Gen. Hospital**

Address..... Date signed.....

#8
6
0

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.....

Roy E Snow

Licensed Embalmer No.....

2560

P. O. Address.....

KC 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.