

State File No. _____

Registrar's No. **603**

FILED FEB 25 1943
Registration District No. **179**

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. 10
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 day (Specify whether
In this community unknown 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. 1012 Cherry
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME John Kennett

3. (b) If veteran, name war No record

3. (c) Social Security No. none

4. Sex M. 5. Color or Race W.

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

6. (b) Name of husband or wife No record

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

7. Birth date of deceased No record
(Month) (Day) (Year)

8. AGE: Years 37 Months No record Days _____ If less than one day
hr. min.

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

10. Usual occupation No record

11. Industry or business _____

MOTHER FATHER

12. Name No record

13. Birthplace No record
(City, town, or county) (State or foreign country)

14. Maiden name No record

15. Birthplace No record
(City, town, or county) (State or foreign country)

16. (a) Informant Record clerk

(b) Address K.C. General Hospital

17. (a) Funeral (b) Date thereof 2-5-43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Leeds

18. (a) Signature of funeral director M. M. Crowe

(b) Address City mentioned

19. (a) 2-5-43 (b) M. M. Crowe
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 17th
year 1943 hour 1:00 A. minute _____ M.

21. I hereby certify that I attended the deceased from 1-16-43 19____ to 1-17-43 19____
that I last saw him alive on 1-17-43 19____
and that death occurred on the date and hour stated above.

Immediate cause of death Meningococccic meningitis

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

Due to 6

Due to _____

Major findings:
Of operations _____

Of autopsy See above diagnosis

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 Mary L. Thon (M. D. or other) _____
Address Med. Dir. K.C. Gen. Hospital Date signed _____

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.....

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.