

FILED APR 8 1943

1464

Registration District No. _____

Primary Registration District No. _____

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:
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 years, months or days) Unknown

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. 7611 Wornall Road
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Ball, James

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

4. Sex Male 5. Color or race w. 6. (a) Single, widowed, married, divorced Unknown

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

7. Birth date of deceased Unknown
(Month) (Day) (Year)

8. AGE: Years app. 70 Months _____ Days _____ If less than one day _____ hr. _____ min.

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

10. Usual occupation none

11. Industry or business _____

12. Name Unknown

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

14. Maiden name _____

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

16. (a) Informant Recd. Clerk Hosp.

(b) Address K. C. Gen. Hosp.

17. (a) Anatomical Board Date thereof 3-27-43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation K.C. Western Dental College

18. (a) Signature of funeral director Snow Mauley

(b) Address 2315 S. Woodward

19. (a) 3-26-43 (b) M. M. Brown
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 23rd
year 1943 hour 8 minute 25 P. M.

21. I hereby certify that I attended the deceased from 2-17-43 19____ to 3-23-43 19____
that I last saw im alive on 3-23-43 19____
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic cardio vascular renal disease

Due to _____

Due to _____

Other conditions _____
(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) _____

(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? college

While at work _____ (Specify type of place) (e) Means of injury _____

23. Signature Dr. R. J. Thon (M. D. or other) _____

Address Med. Dir. K.C. General Hospital Date signed _____

Duration _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

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

MOTHER FATHER

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1464

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.