

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:  
3011 Gillham Road  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 25 years  
(Specify whether 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. 3011 Gillham  
(If rural, give location)  
(e) Citizen of foreign country? Yes (Yes or No)  
If yes, name country.....

3. (a) PRINT FULL NAME Clarence J. Minick

(b) If veteran, name war World War I (c) Social Security No. 702-03-8072

Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married

(b) Name of husband or wife Viola A. Minick 6. (c) Age of husband or wife if alive 46 years

Birth date of deceased January 14 1893  
(Month) (Day) (Year)

AGE: Years 50 Months 3 Days 2 If less than one day hr. min.

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

10. Usual occupation R. R. Maintenance

11. Industry or business

12. Name George W. Minick

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

14. Maiden name Sarah Jane West

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

16. (a) Informant Viola A. Minick

(b) Address 3011 Gillham

17. (a) Burial (b) Date thereof 4-20-1943  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Elmwood

18. (a) Signature of funeral director Freeman Mortuary

(b) Address Kansas City, Mo.

19. (a) 4-19-43 (b) M. M. Crowe  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 16  
year 1943 hour 9:30 minute P.M.

21. I hereby certify that I attended the deceased from 1943 to 1943  
that I last saw him alive on Coroner 1943  
and that death occurred on the date and hour stated above.

Immediate cause of death Crown aneurysm  
Chronic myocardial infarction  
Acute pulmonary edema

Due to 94a  
Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy See above

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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?  
(Specify type of place)

While at work (Specify type of place) (c) Means of injury.....

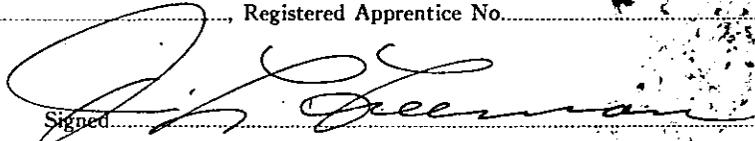
23. Signature: M. M. Crowe (M. D. or other) 3  
Address: 16 C. Mo. Date signed: 4/17/43

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

10-5-1968

**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. 2939

P. O. Address F. O. 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.**