

JUN 7 1943
Registration District No. 149

Primary Registration District No. 1002

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. Convalescent Home 4
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 mo (Specify whether
In this community 10 yrs - years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Jackson
(c) City or town Kansas City
(If outside city or town limits, write "RURAL")
(d) Street No. 3200 Worledge
(If rural, give location)
(e) Citizen of foreign country? unknown (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 25
year 1943 hour 6 minute a M.
21. I hereby certify that I attended the deceased from 5-12-43
19 to 5-25-43;
that I last saw h alive on 5-24-43, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death _____
Due to Arteriosclerosis
Due to 99
Other conditions (Include pregnancy within 3 months of death) _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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 W. H. Wrayana (M.D. or other)
Address 3200 Worledge Date signed 5-26-43

3. (a) PRINT FULL NAME Eus Shephard
3. (b) If veteran, name war No 3. (c) Social Security No. No

4. Sex MO 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 unknown
(Month) (Day) (Year)

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

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

10. Usual occupation no

11. Industry or business _____

12. Name unknown

13. Birthplace 11 (City, town, or county) (State or foreign country)

14. Maiden name unknown

15. Birthplace 11 (City, town, or county) (State or foreign country)

16. (a) Informant K.C. Convalescent Home

(b) Address 3200 Worledge

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-28-43 (Month) (Day) (Year)

(c) Place: burial or cremation Mt Hope, K.C.

18. (a) Signature of funeral director Jean B. Logothian

(b) Address K.C. Mo
19. (a) 5-28-43 (Date received local registrar) (b) M. M. Grove (Registrar's signature)

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

MOTHER FATHER

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

Peter B. Kestner

Licensed Embalmer No. *4773*

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.