

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

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:
General Hospital No. 2
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 8-5-43 9 hrs.
(Specify whether
 In this community 33 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. 1627 Broadway
(If rural, give location)
 (e) Citizen of foreign country? NO (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME JAMES SLAUGHTER

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

4. Sex male 5. Color or race Negro 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 September 6 1892
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
50 10 30 29 hr. min.

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

10. Usual occupation common laborer

11. Industry or business none

12. Name Frank Slaughter

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

14. Maiden name Sidney Slavens

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

16. (a) Informant Record Clerk

(b) Address General Hospital No. 2

17. (a) burial (b) Date thereof 8/9/43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Lincoln Cem.

18. (a) Signature of funeral director Patricia Bros
 (b) Address 1729 Lydia

19. (a) 8-9-43 (b) W. E. Brown
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 5
 year 1943 hour 6:50 minute P. M.

21. I hereby certify that I attended the deceased from 8-5-43
9:30 a.m. to 6:50 p.m.
 that I last saw him alive on August 5, 1943

and that death occurred on the date and hour stated above.
 Immediate cause of death Acute Congestive heart failure & Uremia

Due to Hypertensive type heart disease

Due to 93d

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

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. E. Brown (M. D. or other)

Address Gen. Hosp. #2-600 E. 22nd Date signed 8-6-43

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

APR 23 1951

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.