

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. General Hospital No. 10
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 50 mins.
(Specify whether
In this community No. Record
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. 329 W. 11 St.
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME William Magee

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

4. Sex Male 5. Color or race White 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 May 5th, 1878
(Month) (Day) (Year)

8. AGE: Years 65 Months 5 Days 25 If less than one day _____ hr. _____ min.

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

10. Usual occupation Waiter

11. Industry or business _____

12. Name Magee

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

14. Maiden name Dora Fiesh

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

16. (a) Informant Records at General Hospital

(b) Address K. C. Mo

17. (a) Burial (b) Date thereof 11/9/1943
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Floral Hills Cemetery

18. (a) Signature of funeral director Quirk and Dolin Co.

(b) Address 20 West Linwood, K.C., Mo.

19. (a) 11-9-43 (b) N. E. Brown
(Date received local register) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 30th
year 1943 hour 5 minute 20 A. M.

21. I hereby certify that I attended the deceased from October 30th, 1943 to October 30th, 1943
that I last saw him alive on October 30th, 1943
and that death occurred on the date and hour stated above.

Immediate cause of death Acute urinary retention-cause undetermined

Due to _____
Due to 135 1/2

Other conditions _____
(Includes 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)
(c) Means of injury _____

23. Signature Amey R. Thon (M. D. or other)
Address Med. Dir. General Hosp Date signed 10-30-43

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

MOTHER FATHER

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.