

FILED NOV 19 1943

Registration District No. 149

Primary Registration District No. 1002

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.H. 0
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution Oct. 22-23-43
(Specify whether In this community unknown years, months or days)

3. (a) PRINT FULL NAME JAMES D. SIMMONS

3. (b) If veteran, name war unknown 3. (c) Social Security No. unknown

4. Sex Male 5. Color of 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 unknown

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

8. AGE: Years 75 Months Days If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

MOTHER FATHER

12. Name unknown 9

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

14. Maiden name

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

16. (a) Informant Coroner's office

(b) Address K.C.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-28-43 (Month) (Day) (Year)

(c) Place: burial or cremation Wound Grove Burial Rights

18. (a) Signature of funeral director J. H. [Signature]

(b) Address K.C.

19. (a) 10-27-43 (Date received local registrar) (b) J. E. Brown (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Jackson 48
(c) City or town Kansas City 3
(If outside city or town limits, write "RURAL")
(d) Street No. 548 Main 8
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 10 day 23 year 43 hour 11 minute 30 P.M.

21. I hereby certify that I attended the deceased from 19 to 19; that I last saw him alive on 19; and that death occurred on the date and hour stated above.

Immediate cause of death Coronary artery disease

Due to Atherosclerosis

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations As above

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 J. E. Brown (M. D. or other) Address Date signed 10-28-43

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

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 *Robert J. [Signature]*

Licensed Embalmer No. 4273

P. O. Address KC

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.