S. No. 2
M—2-43
5-17-39
I X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 44,[illegible]

FILED DEC 22 1943

Registration District No. 19

Primary Registration District No. 1002

Registrar's No. 5126

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. 1
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 4 days (Specify whether)
In this community unknown
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 48

(c) City or town Kansas City 3
(If outside city or town limits, write "RURAL") 8

(d) Street No. 547½ Main
(If rural, give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Albert Heath

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 Single

6. (b) Name of husband or wife

6. (c) Age of husband or wife if alive years

7. Birth date of deceased June (Month) 4 (Day) 1863 (Year)

8. AGE: Years 80 Months 5 Days 20 If less than one day hr. min.

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

10. Usual occupation none

11. Industry or business

FATHER
12. Name Heath
13. Birthplace (City, town, or county) unknown (State or foreign country)

MOTHER
14. Maiden name unknown
15. Birthplace (City, town, or county) unknown (State or foreign country)

16. (a) Informant Record Clerk
(b) Address K C Gen Hospt 1

17. State Anatomical (Burial, cremation, or removal) Date thereof 12-7-43 (Month) (Day) (Year)
(c) Place: burial or cremation Dental College

18. (a) Signature of funeral director Lewis-Mayberry
(b) Address KC Mo

19. (a) 12-6-43 (Date received local registrar) (b) N. E. Brown (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November day 24
year 1943 hour 7 minute 15 A.M.

21. I hereby certify that I attended the deceased from November 20, 1943, to November 24, 1943
that I last saw him alive on November 24, 1943
and that death occurred on the date and hour stated above.

Immediate cause of death — Duration
Cerebral Vascular Accident

Due to

Due to 830'

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

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? (e) Means of injury

23. Signature Denny R Thom (M. D. or other)
Address Med. Dir. Gen'l Hosp. Date signed 11-24-43

(Licensed Embalmer's Statement on Reverse Side)

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.....Ray E. Snow.....

Licensed Embalmer No.....2560.....

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.