

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 5164

5164

1. PLACE OF DEATH:

(a) County Kansas 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 Reverend Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 2 days  
(Specify what) \_\_\_\_\_  
In this community 2 days  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson  
(c) City or town Reverend Hospital  
(If outside city or town limits, write "RURAL")  
(d) Street No. Blue Springs Mo  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME James Franklin Saunders

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

4. Sex M 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 Dec. 3, 1943  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
0 0 2 hr. min.

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

10. Usual occupation infant

11. Industry or business \_\_\_\_\_

12. Name Frank Saunders

13. Birthplace Blue Springs Mo  
(City, town, or county) (State or foreign country)

14. Maiden name Ruth Frank  
15. Birthplace Gray Co Kan  
(City, town, or county) (State or foreign country)

16. (a) Informant Mo Ruth Saunders

(b) Address Blue Springs Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 7-43  
(Month) (Day) (Year)

(c) Place: burial or cremation Blue Springs Mo

18. (a) Signature of funeral director Eric J. Swafford, Son

(b) Address Blue Springs Mo

19. (a) 12-7-43 (Date received local registrar) (b) D. E. Brown (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 5<sup>th</sup> year 1943 hour 5 minute 00 P. M.

21. I hereby certify that I attended the deceased from 12-5-43 to 12-5-43  
that I last saw him alive on 12-4-43  
and that death occurred on the date and hour stated above.

Immediate cause of death Respiratory failure

Due to Brain tumor 159

Due to \_\_\_\_\_

Other conditions none  
(Include pregnancy within 3 months of death)

Major findings: none  
Of operations \_\_\_\_\_

Of autopsy none done

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) 0

(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? 0 (Specify type of place) (e) Means of injury \_\_\_\_\_

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

Address 4711 Central Street Date signed 12-6-43

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

MOTHER FATHER

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

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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..... *RB Webb* .....

Licensed Embalmer No. *2353* .....

P. O. Address. *Blue Springs 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.