

FILED FEB 10 1944
Registration District No. **1749**

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
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution **12 hours**
(Specify whether years, months or days)
 In this community **30 years**

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. **4401 Harrison**
(If rural, give location)
 (e) Citizen of foreign country? **0** (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME **RUSSELL K. DOOLITTLE**
 3. (b) If veteran, name war **No**
 3. (c) Social Security No. **494-12-4517**

4. Sex **Male** 5. Color or race **White**
 6. (a) Single, widowed, married, divorced **Married**
 6. (b) Name of husband or wife **Nell**
 6. (c) Age of husband or wife if alive **45** years
 7. Birth date of deceased **August 15th 1900**
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	43	5	5	hr. _____ min.

9. Birthplace **Duer Iowa**
(City, town, or county) (State or foreign country)

10. Usual occupation **Sales man**

11. Industry or business **Clem Chemical Co.**

12. Name **William B.**

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

14. Maiden name **Katherine Duffey**

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

16. (a) Informant **Robert Doolittle**
 (b) Address **4401 Harrison**

17. (a) **Burial** (b) Date thereof **1/22/1944**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Calvary Cemetery**

18. (a) Signature of funeral director **Duich & Davis Co.**
 (b) Address **20 W. Linwood Blvd**
Jan 21 1944 (Date received local registrar)
J E Brown (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **January** day **20**
 year **1944** hour **5:** minute **00** A.M.

21. I hereby certify that I attended the deceased from _____ 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 **Empyema Sobar Pneumonia**
 Due to _____

Due to **109**
 Other conditions _____
(Include pregnancy within 3 months of death)

Major findings:
 Of operations _____
 Of autopsy **See Above**

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)
 (b) Means of injury _____
 23. Signature **A. E. Oberer** (M. D. or other)
 Address **23 Mc Coy** Date signed **1/21/44**

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

MOTHER FATHER

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.