

FILED FEB 3 1944

Registration District No. _____ 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 **3 days**
(Specify whether _____)
In this community **Urban**
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. **914 Cherry**
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **Frank Dusil**
3. (b) If veteran, name war **Unknown** 3. (c) Social Security No. **Unknown**

4. Sex **Male** 5. Color or Race **White** 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
7. Birth date of deceased **Unknown**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
off 68 hr. min.

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

10. Usual occupation **Laborer**

11. Industry or business **Railway**

12. Name **Unknown**
13. Birthplace **Unknown** (City, town, or county) (State or foreign country)
14. Maiden name **Unknown**
15. Birthplace **Unknown** (City, town, or county) (State or foreign country)

16. (a) Informant **Deceased Elb**
(b) Address **Gen Hospital K.C. Mo**
17. (a) **Removal** (b) Date thereof **1/17/44**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Cedar Rfd. Fross**

18. (a) Signature of funeral director **Snow**
(b) Address **2315**
19. **Jan 17 1944** (Date received local registrar) **J. E. Brown** (Registrar's signature)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **January** day **15**
year **1944** hour **8** minute **20** A. M.

21. I hereby certify that I attended the deceased from **January 12**, 19 **44**, to **January 15**, 19 **44**
that I last saw him alive on **January 15**, 19 **44**
and that death occurred on the date and hour stated above.

Immediate cause of death **Far advanced tuberculosis Lung**
Due to _____
Due to _____

Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations _____
Of autopsy **13/1**

Duration
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? _____

While at work? _____ (Specify type of place)
23. Signature **Dr. E. Upsher** (M. D. or other) **11-15-44**
Address **Med. Dir. Gen'l Hosp.** Date signed _____

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

2
43
39
35697

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. *K.C.M.*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.