

FILED FEB 24 1944

State File No. _____

662

Registration District No. 199

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: 709 Washington
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____
(Specify whether _____)

In this community unknown
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Jackson

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

(d) Street No. 709 Washington
(If rural, give location)

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

3. (a) PRINT FULL NAME PERRY F. COLTON

3. (b) If veteran, name war no

3. (c) Social Security No. none

4. Sex MALE 5. Color or race W

6. (a) Single, widowed, married, divorced unk

6. (b) Name of husband or wife _____

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

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 23
year 1944 hour 7 minute a.m.

21. I hereby certify that I attended the deceased from _____, 19____;
Carroll

that I last saw him alive on _____, 19____;
and that death occurred on the date and hour stated above.

8. AGE: Years 92 Months _____ Days _____ If less than one day _____ hr. _____ min.

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

10. Usual occupation UNKNOWN

11. Industry or business _____

12. Name _____

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

14. Maiden name _____

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

Immediate cause of death Arteriosclerotic heart disease

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death) 93d

Major findings: Of operations _____

Of autopsy tracheotomy & history

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

16. (a) Informant CORONERS OFFICE

(b) Address COURT HOUSE

17. (a) REMOVAL (Burial, cremation, or removal) (b) Date thereof 2-9-44
(Month) (Day) (Year)

(c) Place: burial or cremation K.C. DENTAL OFFICE

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

(b) Address _____

19. (a) 2-9-44 (Date received local registrar)

(b) T. C. Brown (Registrar's signature)

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 [Signature] (M. D. or other) _____
Address _____ Date signed _____

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. 4973
P. O. Address 16 - 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.