

Registration District No. 149 Primary Registration District No. 1002

1. PLACE OF DEATH
(a) County Kansas City
(b) City or town Kansas City
(c) Name of hospital or institution 709 Washington
(d) Length of stay: In hospital or institution _____
In this community _____ years, months or days

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Jackson
(c) City or town Kansas City
(d) Street No. 709 Washington
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME JAMES L. HINCHMAN
3. (b) If veteran, name war _____
3. (c) Social Security No. none

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Mar day 11th
year 1944 hour 9:54 minute PM M.
21. I hereby certify that I attended the deceased from _____ 19____ to _____ 19____
that I last saw him _____ 19____
and that death occurred on the date and hour stated above.

4. Sex Male 5. Color or race W 6. (a) Single, widowed, married, divorced unm
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

Immediate cause of death Arteriosclerotic Heart Disease
Due to _____
Due to _____
Other conditions (Include pregnancy within 3 months of death) _____
Major findings: Of operations _____
Of autopsy inspection

7. Birth date of deceased _____ (Month) (Day) (Year)
8. AGE: Years 88 Months _____ Days _____ If less than one day _____ hr. _____ min. _____

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

9. Birthplace _____ (City, town, or county) (State or foreign country)
10. Usual occupation _____
11. Industry or business _____

MOTHER FATHER { 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)

16. (a) Informant Coroner's office
(b) Address 1201 W 11th
17. (a) Removal (b) Date thereof 3-23-44
(c) Place: burial or cremation St. Vincent College
18. (a) Signature of funeral director W. E. Kapitan
(b) Address 1201 W 11th
19. (a) 3-23-44 (b) N. E. Brown
(Date received local registrar) (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) (Means of injury)
23. Signature A. E. Wether (M. D. or other) M.D.
Address 28 McKey Date signed 3/23/44

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

844

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

Debra B. Hoptman

Licensed Embalmer No. *24773*

P. O. Address: *150216*

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.